March 2024

QualiCare

Newsletter

"Don't do as I do, just do as I say"

For years now the medical funding industry has been punishing doctors who charge patients in excess of the medical aid rate by paying the medical aid portion across to the patient instead of to the supplier of service (a terminology which itself is, in my opinion a most derogatory and objectionable reference to a medical doctor).

Unfair Punishment for Balance Billing :
Say for example the guaranteed payment rate was R450.00 and you charged R470.00 by balance billing the patient and the fund, in other words of total bill of R 470.00, you sent a bill to the fund for them to pay the fund liable portion of R450 to you and the same bill to the patient , to pay their patient liable portion, namely R20.00 to you.

Many of the largest funds still pay the patient the R450.00 and you would be the net recipient of R20.00, the patient accepting the windfall of R450.00 towards their monthly housekeeping!

Hats off here to Medscheme who lead the field in reasonability. Within the Medscheme environment, all schemes they administer pay the healthcare providers the medical aid liable portion directly, regardless of providers having balance billed the patient.

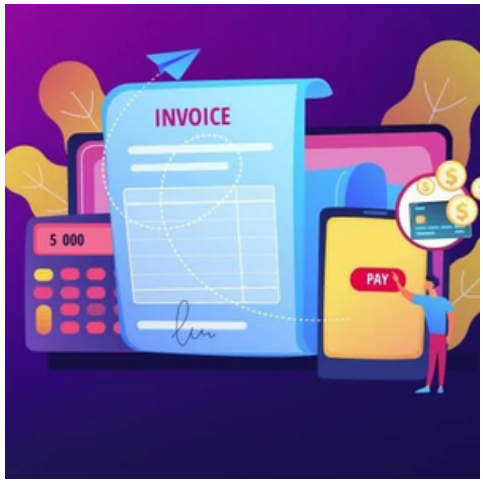
"We will continue to remunerate doctors directly for any and all service provided, be it network or out of network doctors, regardless of amount claimed" says Medscheme.

Inside this issue

Don't do as I do .....continue to page 2

Split Billing:
As opposed to Balance Billing, which is perfectly legal, but is subverted by the funders into a punitive exercise, we all know that split billing is an ethical transgression. This is when two different bills are sent one to the patient and one to the medical aid. This is also a contravention of the National Health act as the patient has to see the full title of their bill.

Split billing would land you in hot water with the regulator.



Ultra Low Cost Benefit options:
Now, enter the new, ultralow cost, bottom of the range LCBO type funds in 2023/4 .....Many funders have found a mechanism of reducing their medical aid liability by creating varying "patient liable" portions in the form of patient co-pays.

These are usually combined with a plethora of rules and regulations to diminish utilisation of the product as well as limit doctor selection, to decide who can be allowed to service these patients, which selection is often based on criteria which have NOTHING to do with patient's health or well-being! (Let me hasten to add that we fully support GP Nomination to stop doctor hopping, limit downstream wastage and improve Outcomes.....).

There are now a number of low-cost products where there are compulsory copayments to the supplier of service. This will need to be reflected on your invoice which you send to the funder, as well as declared to the VAT receiver is there is VAT built into the co-payment.

(This could result in the need to rewrite practice management software specifically for certain low-cost plans at a significant cost passed on to you by your PMS.)

The first response when a doctor, (or should I now say "supplier of service"), is told that he is to charge a co-pay to the patient up front, is to rather absorb that cost instead of annoying the patient, fearing attrition of the patient to another practise who may not charge the co-pay.

In the USA, network doctors who are obliged to collect a co-pay and who fail to do so are expelled from the network by the network administrator. Why, you ask? Because co-pays are placed there to discourage utilisation of the medical aid product by making the patient feel part of the cost in their own pocket.

In South Africa this flies in the face of the wallet free into which we have allowed ourselves to be indoctrinated into accepting for the past 30 years or more!

With the low- cost options burgeoning monthly, the funders have had to find a methodology to reduce the actual cost to the fund, when a patient visits a practitioner. Hence these co-pays will become more and more onerous, under strict circumstances dictated by the funder!

Don't do as I do .....continue to page 3

But Co-Pays are surely the other side of the same the same Balance Billing "coin" , except it is FUNDER INITIATED!!

So now Balance Billing is acceptable when requested by the Funder, but not when initiated by the provider!! What an absolute cheek and abuse of a position of almost total dominance in the market. Now that it suits them to deem a copayment necessary, this upfront payment is suddenly not regarded with the same disdain as if the doctor elects to charge a copayment on schemes which have not built this disincentive into their product offerings.

Surely to level the playing fields, suppliers of medical service (my terminology) should be freely entitled to charge a copayment to whomsoever they feel can afford it and bill the funder the balance of the bill. Come on the other Big Ms and the Big Ds, put on your big boy pants, and pay what your basic rate is, to the doctor. You know that your member will just spend the amount you refund to them on basic necessities and not pay their doctor!!

Have I missed something?
To me it is obvious. It is an abuse of their position of absolute power over the suppliers of service, and it is embodied by the introductory phrase of my article "Don't do as I do just do as I say!"
I openly call on all funding organisations to relinquish the unfair practise of paying the patient when a doctor charges outside of a funders basic scale of benefits rate and to instead pay the insured amount to the doctor and allow the patient to vote with their fee should the doctor charge outside of scale.

The last paragraph of the "Sechaba" judgement makes interesting reading:

Judge of Appeal Wallis expressly ruled on the interpretation of section 59(2) of the MSA when he stated that:

"It seems to me that when a member obtains medical services and arranges for the service provider to submit their account to the medical scheme, they are authorising the medical scheme to pay the service provider and not the member."

The threat of indirect payment (i.e. where the medical scheme elects to pay the scheme member and not the service provider) unless the service provider adheres to any dictates by the medical scheme concerned has presented a significant challenge particularly to medical doctors, who are reliant on being paid directly by the medical scheme.

Indirect payment often means that practitioners are required to institute debt-collection / legal action to recover monies from patients who have been reimbursed by the scheme but have failed, refused or neglected to pay the practitioner monies owing."

Tony Behrman and the QC Team

Notice of CPC/ Qualicare Face-to-Face Open Day 2024

SAVE THE DATE
1st of June 2024

QualiCare

CAPE TOWN ANNUAL OPEN DAY EVENT 2024

SAVE THE DATE 1 June'24

TIME 06:30 - 18:15

CATERING Lunch & Teas

Venue: Biomedical Research Institution, Opposite P5 parking area on the Tygerberg Medical School Campus.

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- *Fun Atmosphere!*
- *Great Food!*
- *A chance to meet face-to-face with your colleagues !!*

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R1,350.00 incl. VAT for NON - CPC Members

Lecture Topics WILL BE OF INTEREST TO Doctors, Dentists & All Allied Health Care Professionals alike.

CPC Shareholder/Member: **YES** ☐ **NO** ☐

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SURNAME:	
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CELL NUMBER:	
LANDLINE NUMBER:	
LOCATION:	
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I hereby permit CPC/Qualicare to share my name,surname and email address with the exhibitors (tick the appropriate box) for purpose of marketing. YES ☐ NO ☐

PLEASE NOTE: THIS NOTIFICATION CAN SERVE AS A TAX INVOICE

Shireen Harris
082 823 8336

Email this form together with your proof of payment to shireen@cpcqualicare.co.za, to secure your place.

(A Total of approximately 22 CPD points will be applied for including 2 Ethics points)

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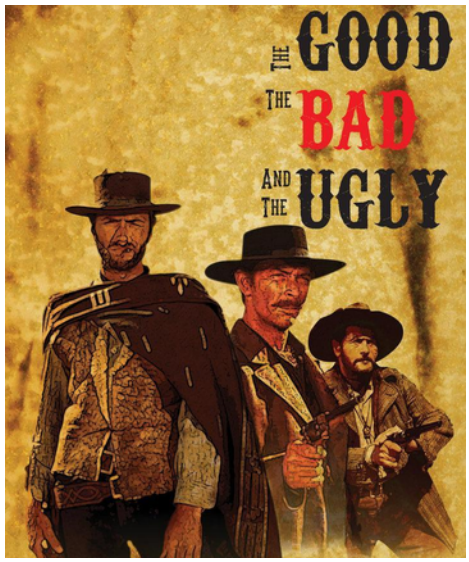
CPC/ Qualicare wishes all of our Muslim Shareholders and Members

RAMADAN KAREEM

Narrow Networks, Narrow Minds, and unfair Competition

The Good the Bad and the Ugly!



Much as we fully agree that health is a priority and to this end repeatedly state the motto of CPC /Qualicare namely :

“To provide Quality, Accessible, Affordable, Non-discriminatory healthcare for all”,

we do not believe that simple Narrow Networks are in the interests of General Practitioners nor our Patients.

Much as we fully agree that health is a priority and to this end repeatedly state the motto of CPC /Qualicare namely :

“To provide Quality, Accessible, Affordable, Non-discriminatory healthcare for all”, we do not believe that simple Narrow Networks are in the interests of General Practitioners nor our Patients.

Narrow Networks:

We are increasingly becoming aware of the formation of:

- new,
- Insurance based
- commercially profit driven,
- low-cost,
- extremely limited benefit,
- difficult to understand and run
- narrow networks using only certain general practitioners, cherry picked from various communities.

A broker entrepreneur will approach the HR department of a significant group in an area which employs blue collar workers and offer to save the company a significant amount on their current medical aid contributions. All they need to do is switch to their new low cost product!

The product is however usually NOT governed by the Medical Schemes Act but rather falls under the Short Term Insurance act, so the doctor enjoys none of the protection or rights written into the MSA.

Furthermore, there is usually a proviso that the members of the new group are confined to only one practitioner only within a radius of 10 to 50 km from a central point in the town, Thus, creating a market disruption in the area, favouring one doctor whilst depriving the other practitioners in the area of their usual patients.

Often however the choice of practitioner has nothing to do with the excellence of a doctor’s outcomes but rather whether that doctor will accept a lower premium for his medical services in return for increased demand for his medical services.

Narrow Networks .....continue to page 7

Invitation to Dentists, Physiotherapists and Allied Health Care Professionals to become an Associate Member of CPC/QUALICARE

Dear Colleagues,

As we approach the new era of increased Government involvement in Health Care Delivery, we anticipate an increase in the speed of implementation of NHI Holding membership of the CPC/Qualicare Network, the largest and most widely representative Medical Network of Healthcare Providers in the Western Cape comprising Doctors, Dentist and Allied Health Care Professionals alike will, we believe, stand in good stead as Government looks to setting up the new Health Care Delivery system for South Africa.

Associate members of CPC/Qualicare offers you the following opportunities:

- Full access to our Monthly newsletter in electronic format.
- Free advertising in our monthly newsletter of your practice related information (max 200 words).
- Free advertising for a locum service, with no commission charges payable.
- Reduced fees to attend our CPC/Qualicare function, at Associate Member's rate.
  (Approximately 30% lower than Non-members rates)
- CPC/Qualicare is committed to providing our members and shareholders with all of their CPC requirements each year. Associate Members receive reduced cost of CPD offerings and other CME offerings compared to non-ember rates.
  (Approximately 30% lower than non-member rates).
- Free listing your practice as part of CPC/Qualicare's Western Cap Electronic Network, your practice will be listed as part of CPC/Qualicare at no charge. (Worth R6000.00 per annum)
- 2 Free stationary items worth R150.00 per month in the form of 1 Prescription pad - 100 leaves, 1 Sick certificate pad - 100 leaves and the ability to purchase further stationary at 30% below current market prices.
- Preferential rates on certain Practice management software systems depending on vendor.
- Inclusion into the CPC/Qualicare Mass email service to receive important health care updates.
- Certain personal banking offerings from commercial banks.
- NHI future possibilities for your practice...Watch this space as NHI starts to roll out!!
- Preferred wholesale and facilitation of opening new accounts with them.
- Assistance with registration of an Integrated Pollution and Waste Information System IPWIS off the Western Cape Government.
- Assist with late medical aid payments, claw-backs, and withholds, as well as advice on practice admin and responses to forensic investigations.

Cost of Associate Membership

- Dentist R416.00 VAT inclusive, per month
- Allied Health Care Professionals R332.00 VAT inclusive, per month

All fees payable by debit order only. Minimum membership period is 12 months with a 3-month notice period thereafter.

Please note that we also offer reduced membership fees for **first time Medical Practitioners** (GP's) in **private practice** for their first year of membership.

Should you be interested in this offering, please email Louna at pa@cpcqualicare.co.za and one of our 5 consultants will make contact with you shortly.

Warm regards,

Dr. Tony Behrman, CEO of CPC/Qualicare
Dr. Solly Lison, Chairman of CPC/Qualicare

Narrow Networks .....continue from page 6

The expectation is that, in return for the guaranteed volumes of patients and despite the lower premiums, and the increased bureaucratic oversight by the Insurance companies behind these plans, the practitioner is expected to continue to offer high quality, value based, patient centric service to the individuals holding membership of those budget low cost and often high demanding options.

The sword of Damocles continuously hangs over narrow network practitioners as there is a waiting list of naive potential doctors to take their place should they step out of line with the administrators of the network but most of whom have NO IDEA what it would actually cost them to practice with a base of low cost patient clients and receive reduced fees but who will need to put in increased time , staffing and effort. Furthermore ,as the network of patients grows, and displaces full fee paying patients from the practice, there are also very deliberately limited opportunities for new doctors to join in at the reduced benefit level; all creating artificial interference with supply and demand.

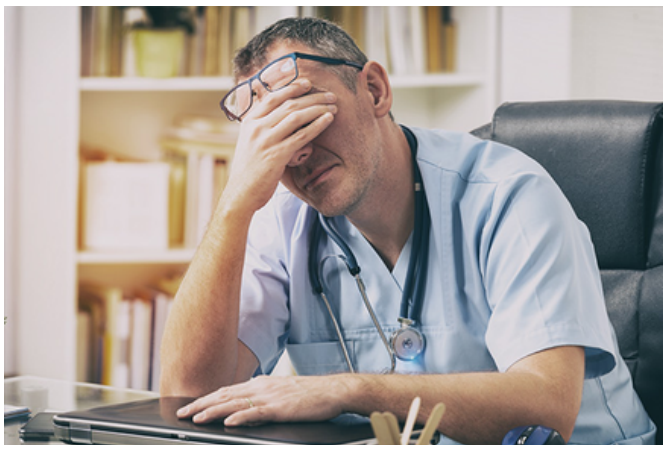
Doctors may be required to stick to formularies based on yesteryears pharmaceuticals, following guidelines last updated years ago by, at best non- clinical advisers who last touched a patient years ago and who hold out that they bear no part in the patient's care but act only as advisers on application of benefits against demands, worsens an already lopsided situation of unfair competition.

Low cost network doctors are easily summarily dismissed, losing large volumes of low- cost, low income patients, many of whom have displaced previous full fee paying patients from their now unpleasantly overcrowded waiting rooms.

Tactically however, it is a clever ploy to limit access to the narrow network to further prospective GPs (holding identical qualifications to their peers but being denied access to patients from a narrow network) whilst simultaneously putting further pressure on the **practitioners who are already in that network** to perform within the demands of the network, observe all the demands of the network managers, whilst still trying to deliver quality services, and then still accepting a non-commensurate reward for such services or face expulsion!

In other words a form of lowest price fixing and creation of an artificial demand for compliant practitioners in return for volume (see the letter in italics below received from one of our members), as well as discrimination against doctors who are readily available but who are unable to comply with the reduced fees offered, as these fees do not cover the fixed overheads of running a general practice.

Low cost insurance plans are like Heroin , the first few doses are free, and the pain soon follows with cash flow difficulties, demanding patients , HPCSA complaints etc, as well as no prospect for future retirement !!



Narrow Networks .....continue to page 10

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Narrow Networks .....continue from page 8

Tiered Networks, Process measure vs Outcomes:

Some of the funders in the formal Medical aid sector use Peer review and peer mentoring and have developed so called Tiered networks , which offer a low remuneration to a category 3 doctor , whilst building up to a higher category doctor for improved excellence in patient care.

Many of their measurement criteria are not always based purely on true patient care , which needs to measure patient Outcomes, but rather on compliance with Process measures , and which themselves have been designed by the funders as long term cost saving tools in disease prevention , rather than measuring real patient outcomes.

In the long term servicing narrow networks at below inflation pricing be they Insurance products or LCBO medical aid products equates to walking in a dead man's shoes, or running to the back deck of the Titanic, as it finally goes down singing " My heart will go on"!

Job Satisfaction, Contentment, Retirement and a moderately comfortable lifestyle are NOT earned by servicing Narrow Networks.

Already, I have noticed with anxiety certain of our members and shareholders debit orders which have bounced because there was just not enough money in the account at the beginning of the month. **Colleagues, narrow networks or not in your best future interests.**

For avoidance of doubt however, **I fully support GP nomination by the patient and sticking to that GP for the year** in an attempt both to bring the family practitioner back into the loop, and to curtail the waste which is currently present in the system as it allows direct specialist referral and does not insist on feedback to the GP! I'm strongly advocating for the family practitioner to be integral in the referral of patients to specialists, and their continued management both in and out of hospital together with specialists as part of an extended multidisciplinary team concept. Collectively we must insist that we become the conductor of the medical orchestra once again.

Finally, I read with interest and empathy the letter below from one of our members (who will be kept anonymous).

"I do understand that XXX Fund has procedures, but it does not unfortunately explain the accreditation of a my relatively new practise in the area and my repeated exclusion, to the detriment of my professional reputation and the management of patients with chronic conditions particularly.

With great joy, I have served this community for a decade and a half and have treated many XXX members and their families for as long.

Patients and myself feel understandably prejudiced against by your exclusionary policy in this regard."

He clearly does not think along the same lines as I do, but I feel his pain nevertheless, at being excluded from seeing patients who were previously supporters of his practice.

Tony Behrman and the Qualicare Team

BALANCE BILL AND BE PROUD OF IT!! (unless you have signed a DSP contract)

Balance Billing has often been avoided by our members due to the common practice exercised by certain medical aids of **"paying their portion"** to the member should the doctor **dare** to Balance Bill. Clearly, they rely on the lack of integrity of their members who, once they receive the money, treat it as though it is a windfall, and leave your accounts on the back burner. This practice is unfair, archaic, unethical and amount to an abuse of the relative differential bargaining positions between the private practitioner and the funder organisations.

Recently, however, a far more progressive stance has been taken by some medical aids which are interacting with the IPAF. Providing you are not a DSP, more and more the medical schemes will pay you **your portion** irrespective of your balance bill. As such you are increasingly liberated from a financial point of view by medical aids that are now "playing fair" on both sides of the divide.

In a recent meeting with Medscheme, we were unequivocally informed that ALL Medscheme Schemes will pay their portion to you irrespective of the amount which you charge the patient andreflect as a balance. Medscheme are to be congratulated on leading the ranks of the "liberated" in this regard.

Remember that **split billing** is unethical and thereby in violation of the Health Professions Act as it breaches the ethical codes of conduct issued by the HPCSA.

Balance billing is totally legal but, as mentioned earlier was undermined by subversive attempts by funders to bully the profession into accepting the medical aid rate in full and final settlement. This they did by paying the portion to the patient should a funder dare to charge in excess of their rate by way of a balance bill.

Balance Bill .....continue to page 12

Unfortunately an entire industry blossomed as a result of the draconian policy with doctors and their billing programs charging **co-payments, levies, facility fees**, administrative fees, etc to the patients "off account", in other words the patients paid these amounts in cash at the point of consultation and were rarely issued with a receipt.

<u>This amounts to split billing and is illegal and cannot be supported by this IPA.</u>

Finally, CPC/Qualicare will not, and has not ever deviated from its motto namely "Cash is King". **Receipt of cash from your patient in a legitimate manner, with full and total disclosure to the Receiver of Revenue, remains CPC's preferred financial model.**

We do however realise the shortcomings of this model and therefore participate in a variety of different reimbursive methods.

(This article first written in 2021 by Tony Behrman)

Tony Behrman and the Qualicare Team

Staying out of trouble with Notification of Death certificates

The importance of correctly identifying a body as well as cause of death – and the subsequent accurate completion of notice of death forms – cannot be over-estimated, says Dr Graham Howarth, Medical Protection Society (MPS) South Africa.

Late last year MedicalBrief reported on the case of a GP who was found guilty of completing "death certificates" on two deceased patients, whose bodies he had not examined before completing the documentation.

It is further alleged that the certificates were then subsequently used in large fraudulent insurance claims. The elderly retired GP was convicted of fraud and sentenced to eight years' imprisonment, wholly suspended for five years.

The deaths occurred during the pandemic and both were certified as being due to natural causes. In this case, the criminal conviction was clearly related to fraud, but the bureaucratic management of notification of death is not without its risks and difficulties.

From the outset it is important to state this article is written based on the contents of the MedicalBrief article on 14 December. Second, it is assumed that while this article refers to the GP having filled in "death certificates", it is more likely that he filled in Notice of Death forms (DHA-1663).

Completion of these Notice of Death forms has certain important administrative functions. They are:

- To confirm the identity of the body to allow for the person's name to be removed from the National Population Register;

· To confirm the circumstances or manner of the death as being from natural causes;

· To give the cause of death that can then be recorded for statistical purposes.

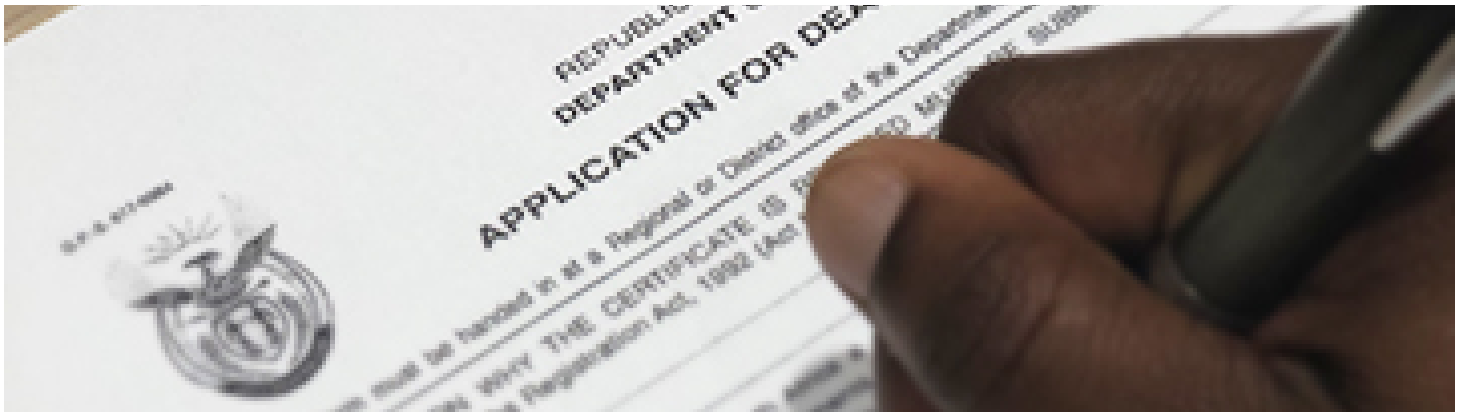
If the clinician is not satisfied that the death was from natural causes, a Notice of Death form should not be completed and a police officer should instead be informed.

Acceptance of the Notice of Death by the Department of Home Affairs allows for the issuing of a Burial Order (DHA-14), which means a body can be disposed of.

Likewise, the department issues an abridged death certificate, which plays an important role in relatives accessing insurance benefits, and issues related to pension claim settlements and settlement of the deceased's estate.

The relevance of correctly identifying the deceased is obvious. The importance of the distinction between natural and unnatural causes of death also cannot be over-emphasised.

Death certificates .....continue to page 14



Excessive administrative oversight of natural deaths is unnecessary and wasteful while the inadequate investigation and oversight of a death from unnatural causes is clearly unacceptable.

If the police are informed that a death is not considered to be due to natural causes the death will then be forensically reviewed and considered by an inquest magistrate who may decide on an informal or formal inquest.

Paraphrasing from the relevant Acts and regulations, deaths from unnatural causes include deaths due to a physical or chemical influence, a death from natural causes where an act or omission of a criminal nature may have played a role, a sudden or unexpected death, or a death where the cause of death is not apparent.

The **Health Professions Amendment Act** adds procedure-related deaths to the list of those considered not to be natural in nature. Our experience at Medical Protection is that procedure-related deaths are probably under-reported. On occasions where there may be a degree of uncertainty that can be resolved by speaking to a state forensic pathologist, the clinician should call the local Forensic Pathology Service and follow the advice, provided while also documenting it contemporaneously in the patient's notes.

If you previously treated the person and you are satisfied that he or she died from natural causes, there is no statutory obligation to examine the body before completing a Notice of Death form.
If you had not previously treated the deceased, but examined the body and are satisfied that the death was from natural causes, you may also complete a Notice of Death form. To be satisfied, you do not have to be certain but must be able to justify on what grounds you were satisfied, should you be challenged.

If you do not have a statutory obligation to examine the body, are satisfied that the death was from natural causes and complete the Notice of Death form without examining the body, you must be ready to justify the documentation if challenged.

Filling out the Notice of Death form.

Some important sections of the Notice of Death form will require specific attention.

It is easy for the unwary, when completing the form, to give the impression of having examined the body. The instructions under Section A of the Notice of Death read:

"To be filled out by the Authorised Medical Practitioner/Professional Nurse, who is responsible for examining the body to determine the cause of death."

If you did not examine the body it may be prudent to score out the words underlined.

Death certificates .....continue to page 15

In Section B of the Notice of Death form there is a paragraph that reads:

"I, the undersigned, hereby certify that I examined the body named in section A and declare that the deceased, to the best of my knowledge and belief, died due to natural or unnatural causes as indicated in paragraph 22."

Again, if you did not examine the body, it would be prudent to score out the section of the paragraph underlined.

Filling out the Notice of Death form.

"I, the undersigned, am not in a position to certify that the deceased died exclusively due to natural causes."

If you tick this section, you should not be completing the form, and should rather tell a police officer you are not satisfied death was from natural causes.

Finally, you are asked to comment on the method used to ascertain the cause of death. If you did examine the body, then you may tick 79.2 (post-mortem examination), which refers to having examined the body (as opposed to 79.1 where an autopsy has been performed).

If you did not examine the body, you should consider ticking 79.3 stating that the cause of death was based on the clinician's opinion. Under 79.7, under other, you could add: "Body not examined".

Without all of the above-mentioned suggestions, it is possible that the doctor concerned inadvertently gives the impression that the body was examined – and allegations of deceit or dishonesty may be made.

A clinician who has previously treated a patient does not have a statutory obligation to examine the body, and may complete a Notice of Death form if satisfied that death is from natural causes.

Clearly the option least likely to lead to criticism is to examine the body before completing a Notice of Death form. This will lessen the risk of criticism regarding identification, and satisfy that death was from natural causes.

Before completing the form, it may be worthwhile reflecting on what your understanding is of the death having been from natural causes – in case you are challenged. Likewise, a clinician who has not previously treated a deceased may complete the form, if after examining the body he or she is satisfied it was a natural death.

Section D of the Notice of Death form reveals the details of the informant – the person responsible for verifying the identity of the body. Being able to fully trust the informant, particularly if the body is not examined, is of cardinal importance, especially if you are later challenged on the identification.

Sadly, fraud is rife and if the informant misleads a clinician that could be to the clinician's disadvantage – and may even extend to criminal liability.

In summary, if you are asked to complete a Notice of Death form, always reflect carefully on your responsibilities and be cognisant of how you can be misled.

Be aware of how an informant may mislead you, how well you know the person, and whether they are trustworthy. Have a low threshold for challenging that person. If you have previously treated the patient, do you have enough information to satisfy yourself that the death was from natural causes without examining the body?

Even if you do not have a statutory obligation to examine the body, having a low threshold for going out and examining the body is always the safer option. Likewise, even if you examine the body would you be able to defend your position of being satisfied that death was from natural causes?

If in doubt, speak to a local state forensic pathologist and document and follow their advice. Above all, be diligent, be vigilant and be careful.

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Celebrating Decades of Partnership

In the dynamic landscape of business, building enduring relationships is an art that few master. However, in the case of Mr Deryck Pike and Dr Tony Behrman, their longstanding connection stands as a testament to the power of collaboration, trust and shared values. Their journey together, spanning over decades, mirrors the commitment to excellence that has defined GRID Wealth and its relationships with the members and practices of CPC.

From Left : Mr Craig Pike, Mr Bethram Nkosi, Dr Tony Behrman, Mr Deryck Pike

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Thank you,

Qualicare Team

HOW SOUTH AFRICA IS LEGISLATING ITS WAY INTO A HEALTHCARE CRISIS

Clumsy law-making on healthcare and the failure to correct it have resulted in medical schemes carrying an almost unlimited liability for prescribed minimum benefits (PMBs), while nearly 10 million people are being denied low-cost benefits for primary healthcare.

Unregulated consultant tariffs and the reluctance of the **Council for Medical Schemes** (CMS) — the government's chief proxy — to approve low-cost benefits schemes are driving medical inflation and sending medical aid premiums soaring, according to Rajesh Patel, the head of health systems strengthening at the Board of Healthcare Funders (BFH), and Charlton Murove, the head of research.

They said the **National Health Insurance** (NHI), which looms on a 10- to 20-year time horizon, would effectively put paid to medical schemes. The government says the **NHI aims to** enable equitable access to quality healthcare.

The BHF is the representative organisation for the majority of medical schemes in South Africa, Namibia, Zimbabwe, Botswana and Lesotho.

Patel and Murove said healthcare in South Africa is unnecessarily complex, with dismal regulatory oversight in which patients suffer financial hardship while struggling to negotiate a healthcare funding jungle.

Against this backdrop, industry experts have welcomed a recent web-based innovation, **MedicalAid.comm**, which provides accurate medical aid comparisons through a sliding premium affordability button while listing benefits.

"One of the biggest oversight challenges is PMBs [prescribed minimum benefits] — a set of conditions which medical schemes are obliged to pay for in full — but have no idea what they're in for," Murove said.

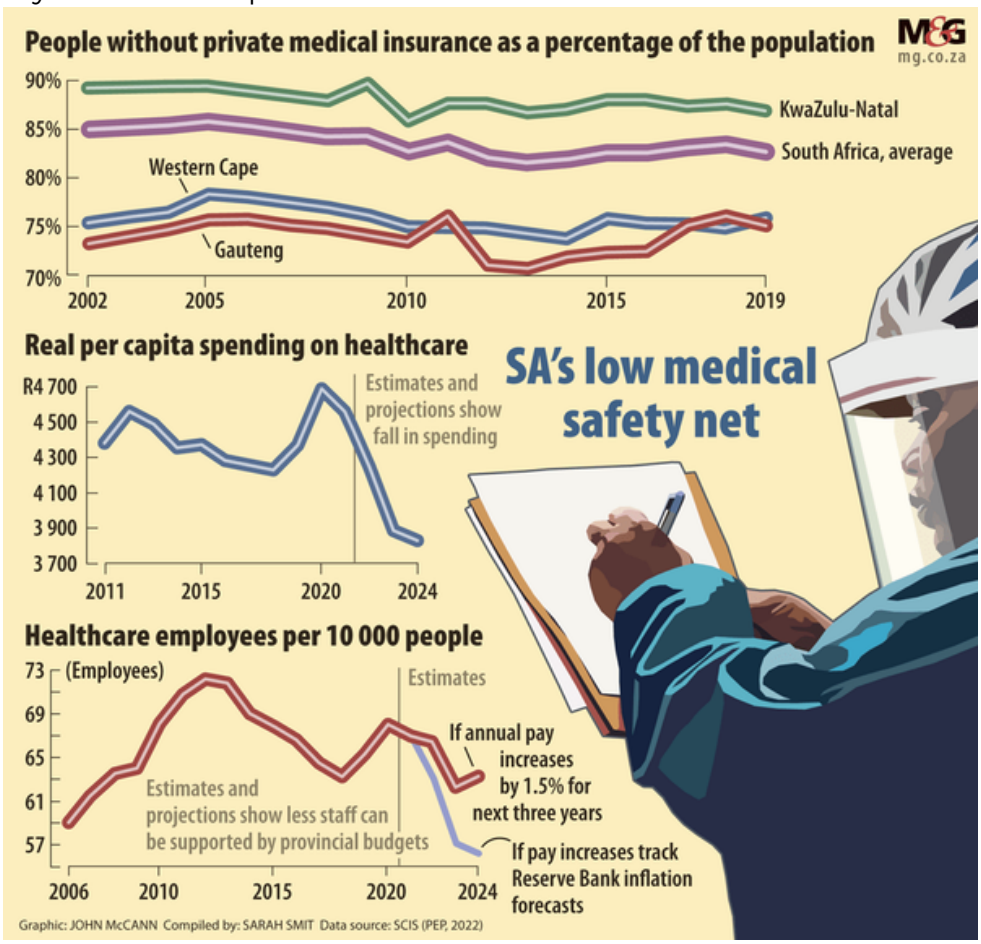
How South Africa .....continue to page 19

"To make matters worse, healthcare practitioners (consultants mainly), determine the cost, often charging more than their usual tariffs when it's a PMB-related condition. There's also upcoding, which is when a healthcare provider makes a PMB-related diagnosis so they can get access to this unlimited bucket of funds."

Prescribed minimum benefits are poorly defined in regulation, creating too many grey areas that can be taken advantage of, Patel weighed in.
"South Africa's version, passed in 2003, was based on research done in Oregon in the United States, except that there, they have put in place defined procedures and coding, while here we've dropped the technical specifications, blurring interpretations," Patel said. "So, service providers are incentivised to charge as much as possible.

"When you access a consultant, you don't know the cost and you're not able to negotiate. While there are Health Professions Council of South Africa ethical rules around informed consent, in practice this doesn't occur enough. There's often no discussion around price, irrespective of PMBs. Often a patient goes to a doctor and the receptionist asks: 'Do you have gap cover?'

"If you say yes, they charge more. People don't know about PMBs and non-PMBs. Also, when you are sick, you're at your most vulnerable. If, for example, you have cancer — are you able to say let's negotiate a price for my care?" Murove posited.



Even for those who work in this environment, it's a minefield, Patel said, calling for better stewardship and oversight.

How South Africa .....continue to page 20

“We’re currently sitting with a politicised healthcare system. There is more politics at play than efforts to solve the problem.”

Allowing more affordable low-cost benefit options (medical aid products, not insurance) would enable people who cannot afford higher end medical plans to at least access primary healthcare products, Patel said, taking a huge burden off the state.

He noted that the Competition Commission’s 2019 Health Market Inquiry chaired by former chief justice Sandile Ngcobo had said there should be some consultant tariff ceiling and made specific recommendations, but the health department had not moved on implementing any of them.

“We applied for exemption from the Competition Commission so we could do collective bargaining while the government gets its act together, but politics came into play, and we’ve now been sitting with the Competition Commission for over two years.”
Patel said a holistic review of PMBs and allowing low-cost benefit options (LCBOs), “would change the entire environment”, but bemoaned the shortage of skills and seeming lack of will in the health department and the CMS.

“The [department] has simply relegated it to the CMS who haven’t moved on this for nearly eight years. I mean a single medical aid can change its benefits within one year, but the CMS seems incapable. They say they’re busy reviewing PMBs, but it’s treacle-slow,” he added.
Murove went further, accusing the CMS of deliberately trying to frustrate the feasibility of medical schemes to further the NHI — while rendering patients vulnerable.

“We’ve taken them to court on judicial review and what we saw in their documentation was a very deliberate attempt to delay LCBOs as much as possible. We can clearly see that if they did approve LCBOs, the NHI would become less appealing to the public,” he said.

“Approving LCBOs would make a big difference to millions of lives, especially with the medical tax savings — and medical schemes would be far more sustainable. In the [department of health’s] estimation allowing LCBOs will create a bigger pool of people who won’t need an NHI because they’re being looked after by medical schemes.”

Both Patel and Murove said that young and healthier patients were moving to unregulated insurance products, leaving the sick and older people in medical schemes and creating “a vicious cycle” in which medical aid premiums were becoming increasingly expensive.

“The more this happens the more youngsters (often newly married with young children) move out into insurance, leaving older people paying increasingly. Medical aids will just get increasingly expensive — which suits the NHI proponents,” Patel said.

“If you want social solidarity you need to reduce the number of risk pools. If you don’t attract the young people, you can’t keep contributions down and you’ll always have contributions more than CPI [consumer inflation] plus five percent.”

Murove and Patel said both the BHF and the Orthopaedic Society of South Africa had applied for exemption from the Competition Commission.

“Between the funders and the service providers there’s an urgent need to sit around the table to discuss what’s reasonable and fair pricing.

How South Africa .....continue to page 21

Hopefully, the regulators will come to the table, and we can do real structural reform. Let the players find their own solution instead of the [health department] ignoring our input. We're not against universal healthcare. We just want to reduce pressure on the healthcare system and have input into NHI benefits. LCBOs would be a primary healthcare package, like an entry point to the NHI environment — a mutually beneficial one."

They said the failure to implement the recommendations of the Health Market Inquiry "makes no sense in the bigger scheme of things" and that allowing low-cost benefit options under the CMS would provide "fertile ground" to trial healthcare provision in an NHI environment.

"It seems clear that the government has a perception that if you improve the medical scheme environment it will be a threat to NHI implementation. It seems clear that people on medical aid schemes will be the last to be brought into the NHI. However, if you trial a partnership with the private sector now, you'll reduce the burden on the state and can then eventually wind down on the medical schemes when it becomes an easy migration," Patel said.

The pair said offering low-cost benefit options packages at affordable premiums of about R200 to R300 a month for primary health cover would enable as many as 10 million people to benefit.

"Many are willing to pay from their own pockets to avoid taking time off work or losing income waiting in the public sector. It's a significant number — and the medical tax credit they'd get just further increases the potential," Patel added.

Media coverage of the government's position revealed huge suspicion of the private sector as purely profit driven, Patel said.

"Instead, what's true is that our sector has done much to add value. It's sad that they see us in this way. It shows a lack of understanding. What they're describing as bad in the insurance environment is something they're perpetuating. They cite medical schemes' administration costs. Well, LCBOs can be self-administered with nobody making any profit," he argued.

"For those in the insurance market, moving to a medical scheme will be a great boon via the tax rebate. If an insurance product is not performing, they can increase premiums and cut benefits — and there's no insurance ombudsman to run to. There's been a deliberate misunderstanding of the facts and criticism of LCBOs."

Asked about allegations of some doctors "gaming the system" by conducting unnecessary procedures, the chief executive of the South African Private Practitioners Forum (SAPPF), Simon Strachan, said although it did not have a monitoring mechanism, the profiling of doctors was done by almost every medical scheme administrator — or by the hospital itself for hospital-based consultants.

Many specialities and medical organisations partnered with funders to profile pre-identified "outlier" practices. Any suggestion that consultants were inflating their prices was "simply wrong", he added.

"You have a duty to discuss payment options with your patient. I see nothing wrong in asking patients how they aim to pay for your services. One thing the SAPPF is very clear on is that healthcare professionals should have a one-off fee, not one for prescribed minimum benefits, and another for non-PMBs. You can decide whether to discount that fee or not. If you have gap cover, I should still charge you my regular fee."

CMS registrar Sipho Kabane said a full report with multiple stakeholder input on low-cost benefit options, dating to before the Covid-19 pandemic, was given to Health Minister Joe Phaahla last November and included the CMS advice on the main recommendations made by the Health Market Inquiry.

"We've added our regulatory perspective — I don't want to muddy the waters now by commenting," he said.

A CMS review on what should be included in PMB conditions, in line with scientific evidence, cost effectiveness and the protection of members and medical schemes was underway. One thrust would be including elements that reduced the need for curative and hospital services, thus improving health outcomes.

"We believe the only protection you enjoy as a medical scheme member are PMBs, which are a compulsory payment by schemes. We don't think it makes sense to interfere and tamper with them," Kabane added.

The CMS application to the appellate division of the supreme court in its legal wrangle with the BHF, due to be heard in April or May this year, could be rendered moot by the health minister's decision.

"I'm sure we can find an amicable way to resolve the dispute," he said.

England's NHS hidden waiting lists terrifying patients

Patients are facing delays stuck on hidden waiting lists that do not show up in the official figures in England, a BBC News investigation reveals.

The published waiting list stands at 7.6 million - but the true scale of the backlog is thought to be much higher. This is because patients needing ongoing care are not automatically included in those figures - even if they face major delays.

NHS England said hospitals should be monitoring and counting such cases.

But BBC News found evidence suggesting this is not always the case.

The problem affects patients receiving ongoing care, as well as those removed from waiting lists even before starting treatment.

BBC News has spoken to patients waiting months and even years for vital treatment, such as cancer care, spinal treatment and others at risk of going blind because of deteriorating eyesight.

'Really worrying'

One of those is Andy Allen, 69, from Chelmsford, who has wet AMD, which causes vision to deteriorate.

He needs regular eight-weekly injections to protect his sight, but says he often waits longer with the latest gap being more than twice as long as it should be.

"It's really worrying. My eyesight is getting worse - and I do wonder if it is because of the delays."

Macular Society charity chief executive Cathy Yelf called the delays in the system a "tragedy".

England's NHS .....continue to page 24

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References: 1. CLOZABAM ADCO 10 & 20 mg tablets Professional Information, 27 June 2023. 2. Faulkner MA. Comprehensive overview: efficacy, tolerability, and cost-effectiveness of clobazam in Lennox-Gastaut syndrome. *Ther and Clin Risk Manage* 2015;11:905-914. 3. Generics dictionary. http://www.generic.co.za/frontend/generics?utf8=%E2%9C%93&q%5Bactive_ingredient_name_eq%5D=CLOBAZAM (Accessed: 03 October 2023).

For full prescribing information please refer to the Professional Information approved by SAHPRA (South African Health Products Regulatory Authority).

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"People are terrified at the prospect of losing their sight," she added.

The official waiting list tracks patients waiting to begin treatment.

Around 1.4 million treatments are recorded as beginning each month on average - with one in three affected by delays, according to data for 2022-23.

But there are more than 3 million other appointments and treatments carried out for patients who are receiving ongoing care.

Many will be getting timely care, but how many of those are delayed is not known. Some say millions could be affected over the course of a year.

'Commonly ignored'

Hospitals are meant to return patients facing unnecessary delays to the waiting list to ensure they are counted in the backlog figures.

But of 30 NHS trusts asked by BBC News how regularly this was happening, only three could provide figures.

Karen Hyde, from Insource, a company that helps hospitals manage waiting lists, said the guidance was "commonly ignored".

"This is a huge issue. The NHS does not incentivise hospitals to keep a close eye on these patients.

"We know there are long waits for those on the waiting list. For those not on the official waiting list, it is likely to be even worse - but the figures are not published."

- **One million on more than one NHS waiting list**
- **Sunak admits he has failed to cut NHS waiting lists**

She said another problem was that some patients face being taken off the waiting list before treatment starts - this can be done when the patient is not ready for treatment or if they have refused it.

But she said many hospitals had no reliable systems for tracking these patients, who could be simply "lost and delayed".

This has happened to Margaret Weston, who has basal cell carcinoma, a slow-growing form of skin cancer.

The risk of it spreading is very low, so the 64-year-old, from Lincolnshire, has been under the care of doctors in the East Midlands for the past few years.

But with three separate hospitals involved in her care, a mix-up saw her removed from the waiting list.

England's NHS .....continue to page 25

Ms Weston has now been upgraded to an urgent case and is waiting for surgery.

"It is so easy to fall through the gaps. Hospitals aren't monitoring these waits and not recording it properly.
"I'm terrified about what might happen now," she said.
'Irreversible damage'

Another patient BBC News has spoken to is now exploring taking legal action, after being put on a "holding" waiting list despite struggling with severe abdominal problems. Hospital letters about their case, seen by BBC News, acknowledge these lists are not "manned routinely" and patients can be held up in the system.

Labour shadow health secretary Wes Streeting said the revelations were "utterly shocking".

He said if Labour won the election he would ensure the full extent of the hidden waiting lists were published "so we can level with the public and even more importantly take the action necessary to get those lists down".

Macmillan Cancer Support policy head Minesh Patel said patients receiving regular chemotherapy and radiotherapy - and those under surveillance to check if their cancer had returned - also faced delays.

"NHS staff are doing all that they can - but with limited resources, it's impossible for them to keep up," he added.

The British Heart Foundation said heart failure patients were at particular risk as they needed regular check-ups to ensure treatment was working.

A delay to changes in treatment could lead to "permanent and irreversible damage", the BHF's Dr Sonya Babu-Narayan said.

Health Foundation data analytics director Charles Tallack said there was too little focus on these "hidden waits".

"It's clearly a major problem - delays are putting patients at risk. We need better monitoring and oversight to see exactly what is happening."

An NHS England spokeswoman said: "National guidance is clear that if a regular follow-up review or treatment becomes overdue and a patient is waiting longer than the time agreed with their clinician, they should be added back on to the waiting list and therefore would be included in published figures."

The Department of Health and Social Care said cutting waiting times was one of the government's top five priorities, adding: "We expect trusts to comply with the guidance."

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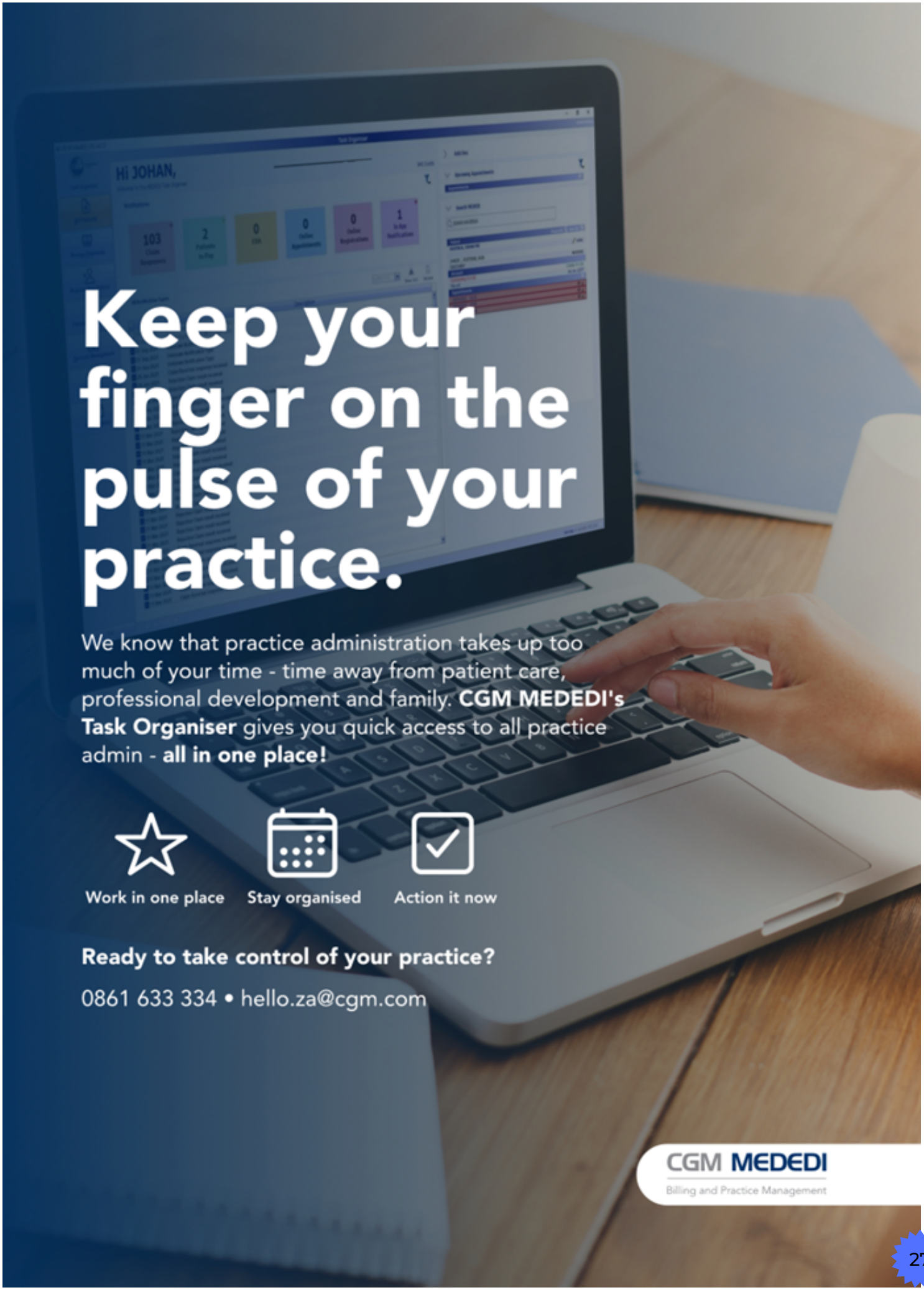
Worcester Open Day

Date: 19 October 2024
Venue: Worcester Faculty of Medicine and Health Sciences, Stellenbosch University, Campus, 1 Durban Street



THE PATHCARE NEWS

PRE-OPERATIVE SCREENING AND THE PREVENTION OF PROSTHETIC JOINT INFECTION

Prosthetic joint infection (PJI) occurs in approximately 1% of all cases of total joint arthroplasty. To mitigate this complication, pre-operative management of patient risk factors are important to improve the outcome of surgery.

Pre-operative Urine screening – NOT RECOMMENDED:

The International Consensus on Periprosthetic Infection meeting supported by the Musculoskeletal Infection Society and the European Bone and Joint Infection Society (EBJIS) agreed in 2013 that routine urine screening is not warranted for patients undergoing elective arthroplasty.[1] Current evidence does not support the treatment of asymptomatic bacteriuria (ASB) prior to non-urologic surgery.

When should urine cultures be requested?

- *In asymptomatic patients with no specific symptoms of urinary tract infection (UTI) routine urine screening is not recommended prior to elective joint arthroplasty.*
- *Urine culture should only be requested in patients with symptoms suggestive of UTI. Symptomatic UTI should be treated before surgery due to the risk of hematogenous seeding to the joint.*

What are the negative consequences of routine urine screening?

Routine urine screening and culture of asymptomatic patients increases antibiotic prescriptions for ASB. This unnecessary exposure to antibiotics:

- Impacts the normal flora negatively with an increase in antibiotic resistant colonizing flora
- Increases the risk for *Clostridioides difficile* infection
- May cause adverse drug effects
- Increases costs due to laboratory tests, antibiotics prescribed and associated costs with adverse effects

Treatment of ASB may be harmful to the patient as illustrated by a study by Cai et al. showing that in in a cohort of women with recurrent UTI, treatment of ASB was associated with a higher rate of symptomatic UTIs and a higher prevalence of antibiotic-resistant bacteria. It is suggested that ASB may have a protective role in preventing symptomatic infection.[2]

Is it safe to eliminate pre-operative urine cultures?

- The elimination of routine urine culture before orthopaedic surgery has been shown to reduce antibiotic utilization and did not affect surgical site infection (SSI) and catheter-associated urinary tract infection (CAUTI) rates.[3]
- A 2019 meta-analysis showed that pre-operative treatment of ASB did not lower the risk of PJI or post-operative UTI.[4] The majority of cultured PJI bacteria were different from the isolates found in the urine of ASB cases. Pre-operative antibiotic treatment did not show any benefit and cannot be recommended.
- **Several institutions report that the cessation of routine urine screening prior to non-urologic procedures can be safely implemented and improve value of care.**[3,5,6]

Pre-operative *Staphylococcus aureus* screening and decolonization -RECOMMENDED:

Why should patients be screened for Staph aureus prior to elective orthopaedic surgery?

S. aureus colonization is an important risk factor for PJI and rates of SSIs are reported to be nine times higher in carriers compared to non-carriers.[7] Malcolm et al. reported that the implementation of a screening and decolonization protocol can significantly decrease revision arthroplasty due to PJI. Universal decolonization pre-operatively without screening for *S. aureus* may contribute to mupirocin resistance and cannot be advocated.

How is S. aureus screening done?

S aureus carriage cannot be predicted based on patient characteristics and necessitates individual testing. Bacterial culture or PCR methods can be used to screen for colonization. However, only culture-based methods can be used to determine mupirocin susceptibility. The nose is the most common site colonized by *S. aureus,* but screening multiple sites can increase the sensitivity of detection. A combination of three swabs from different sites provide the highest detection rate with the best combination being that of nasal/throat/groin or perineum or rectum.[8]

We process all swabs submitted for *Staph aureus* screening together to reduce costs and due to the fact that the decolonization protocol will not differ depending on the site colonized. Indicate on the request form the correct screening test:

- MRSA/MSSA culture (swab nose, throat + perineum) – test mnemonic: MISA [1 lab no. for all swabs]
  Turnaround time (TAT): 2-4 days
- MRSA/MSSA PCR (swab nose, throat + perineum) – test mnemonic K2413 [1 lab no. for all swabs]
  TAT: 24hrs after reaching the molecular lab. The PCR test is more costly.

The laboratory will report if MSSA or MRSA detected. The culture method will indicate if the isolate tested susceptible or resistant to mupirocin.

If a nose swab MC&S is requested, a different laboratory protocol will be applied and each swab will be processed and billed separately.

Decolonization protocol:

A systematic review of *S. aureus* screening and decolonization prior to orthopedic surgery, showed that in the majority of studies a decolonization protocol was instituted 5 days prior to surgery. These protocols mostly involved a combination of 2% mupirocin nasal ointment and daily chlorhexidine body washes. All the studies included in this review showed a reduction in SSIs.[9] In cases of mupirocin resistance, neomycin-chlorhexidine (Naseptin®) nasal cream may be used as an alternative agent.

Compiled by Dr Heidi Orth, Clinical Microbiologist at PathCare, January 2024

References:

1. Parvizi, J et al. Proceedings of the International Consensus on Periprosthetic Joint Infection. *Bone Joint J 2013*;95-B:1450–2.
2. Cai, T et al. Asymptomatic bacteriuria treatment is associated with a higher prevalence of antibiotic resistant strains in women with urinary tract infections. *Clin Infect Dis 2015*; 61(11): 1655-61
3. Hollenbeck, BL et al. Elimination of Routine Urinalysis before Elective Orthopaedic Surgery Reduces Antibiotic Utilization without Impacting Catheter-associated Urinary Tract Infection or Surgical Site Infection Rates. *Hip Pelvis 2021*; 33(4): 225-230.
4. Sousa, RJG et al. Is Routine Urinary Screening Indicated Prior To Elective Total Joint Arthroplasty? A Systematic Review and Meta-Analysis. *The Journal of Arthroplasty 2019*; 34 (7): 1523-1530.
5. Hellinger, WC et al. Improving Value of Care: Cessation of Screening Urine Culture Prior to Orthopedic and Spinal Surgery. *Mayo Clin Proc Inn Qual Out 2020*;4(2):126-131.
6. Partridge, JSL et al. Using implementation science to develop and implement a guideline to reduce unnecessary preoperative testing for asymptomatic bacteriuria prior to elective arthroplasty. *J. Bone Joint Infect 2020*; 6: 57–62.
7. Malcolm, TL et al. Predictors of *Staphylococcus aureus* Colonization and Results after Decolonization. *Interdisciplinary Perspectives on Infectious Diseases 2016;* Article ID 4367156
8. Chipolombwe, J et al. (2016) Methicillin-resistant *Staphylococcus aureus* multiple sites surveillance: a systemic review of the literature. *Infection and Drug Resistance. 2016*; 35-42.
9. Chen, AF et al. *Staphylococcus aureus* Screening and Decolonization in Orthopaedic Surgery and Reduction of Surgical Site Infections. *Clin Orthop Relat Res 2013*; 471:2383–2399.

HOW 100-YEAR-OLD TB VACCINE CAN BE NEW ALZHEIMER'S WEAPON

Recent studies have suggested that the **BCG** jab – the tuberculosis vaccine that has saved millions of lives since discovery a century ago – could provide a cheap, effective way of boosting the immune system to protect people from developing **Alzheimer's** disease.

In the early 1900s, in France, doctor Albert Calmette and veterinarian Camille Guérin aimed to discover how bovine tuberculosis was transmitted. But they first had to find a way of cultivating the bacteria.

Sliced potatoes – cooked with ox bile and glycerine – proved to be the perfect medium.

As the bacteria grew, however, Calmette and Guérin were surprised to find that each generation lost some of its virulence. Animals infected with the microbe (grown through many generations of their culture) no longer became sick but were protected from wild TB.

In 1921, the pair tested this potential vaccine on their first human patient, a baby whose mother had just died of the disease. It worked, and the result was the **Bacille Calmette-Guérin** (BCG) vaccine that has saved millions of lives.

Now, a string of intriguing studies suggests that BCG can protect people from developing Alzheimer's disease.

New Alzheimer's weapon .....continue to page 31

If these preliminary results bear out in clinical trials, it could be one of the cheapest and most effective weapons in our fight against dementia, reports The Guardian.

Around 55m people now have have dementia, with about 10m new cases each year.

Alzheimer's is the most common form, accounting for about 60%-70% of cases, and characterised by clumps of amyloid beta protein that accumulate within the brain, killing neurons and destroying the synaptic connections between the cells.

Exactly what causes the plaques to develop has been a mystery, but multiple lines of evidence implicate problems with the immune system.

As youngsters, our body's defences can prevent bacteria, viruses or fungi from reaching the brain. As we age, however, they become less efficient, which may allow microbes to work their way into our neural tissue.

According to this theory, the amyloid beta is produced to kill those invaders as a short-term defence against infection. If the brain's own immune cells – microglia – were working optimally, they could clear away the protein once the threat has passed. But in many cases of Alzheimer's, they seem to malfunction, triggering widespread inflammation, leading to further neural carnage.

Much evidence now supports this theory. Autopsies have revealed brains of people with Alzheimer's are more likely to be home to common microbes such as the herpes simplex virus, the cause of cold sores. Crucially, these germs are often entrapped in the amyloid, which has been proven to have antimicrobial properties.

If this theory is correct, attempts to boost the immune system's overall functioning could prevent the development of the disease.

New approaches are needed. After decades of research on ways to clear the plaques, only two new drugs have been approved, both based on antibodies that bind to the amyloid beta proteins, triggering an immune response that clears them out of the brain.

This appears to slow disease progression in some patients, but the improvement in overall quality of life is often limited. Anti-amyloid antibodies are also expensive, "which is likely to lead to an enormous health equity gap in lower-income countries", says Marc Weinberg, who researches Alzheimer's at Massachusetts General Hospital in Boston.

Existing vaccines like BCG might offer an alternative solution. Decades of research show BCG can have wide-ranging benefits extending beyond its original purpose.

Besides protecting people from TB, it seems to reduce the risk of many other infections: in a recent clinical trial, BCG halved the odds of developing a respiratory infection over the next 12 months, compared with the people receiving a placebo.

BCG is also used as a standard treatment for forms of bladder cancer. Once the attenuated bacteria have been delivered to the organ, they trigger the immune system to remove the tumours, where previously they had passed below the radar.

These effects are thought to emerge from a process called "trained immunity". After an individual has received BCG, you can see changes in the expression of genes associated with the production of cytokines – small molecules that can kick our other defences, including white blood cells, into action.

So the body can respond more efficiently to a threat, be it a virus or bacteria entering the body, or a mutant cell that threatens to grow uncontrollably.

There are good reasons to believe trained immunity could reduce the risk of Alzheimer's. By bolstering the body's defences, it could help keep pathogens at bay before they reach the brain.

New Alzheimer's weapon .....continue to page 33

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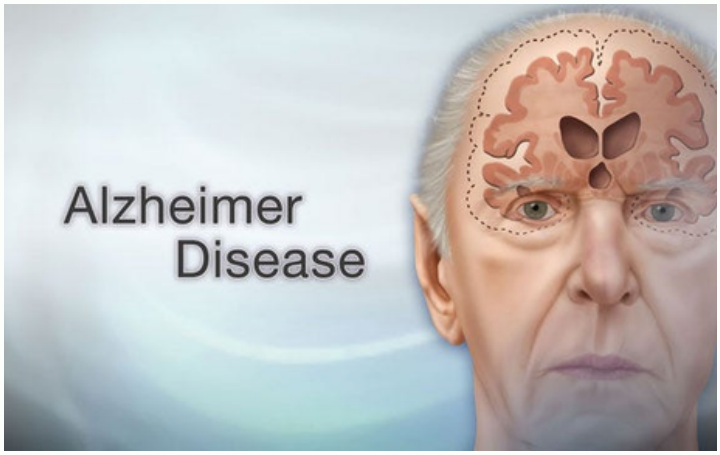

It could also prompt the brain's own immune cells to clear away the amyloid beta proteins more effectively, without causing friendly fire to healthy neural tissue.

Animal studies provide some tentative evidence. Laboratory mice immunised with BCG have reduced brain inflammation, for example. This results in notably better cognition, when other mice of the same age begin to show a steady decline in their memory and learning. But would the same be true of humans?

To find out, Ofer Gofrit of the Hadassah-Hebrew University Medical Centre in Jerusalem and his colleagues collected the data of 1 371 people who had or had not received BCG as part of their treatment for bladder cancer.

Just 2.4% of the patients treated with BCG developed Alzheimer's over the next eight years, compared with 8.9% of those not given the vaccine.

Since then, other researchers have replicated the findings. Weinstein's team, for instance, examined the records of about 6 500 bladder cancer patients in Massachusetts.

Crucially, they ensured that the sample of those who had received BCG and those who hadn't were carefully matched for age, gender, ethnicity and medical history. The people who had received the injection, it transpired, were considerably less likely to develop dementia.

The precise level of protection varies between studies, with a recent meta-analysis showing an average risk reduction of 45%. If this can be proven with further studies, the implications would be huge.

Plenty of caution is necessary. Existing papers have all examined patients with bladder cancer, but there is little data on the general population. One obvious strategy may be to compare people who have received the BCG vaccine during childhood with those who hadn't, but the effects of BCG may dwindle over the decades – long before most people would be in danger of developing Alzheimer's.

We can, however, examine the effects of other vaccines delivered in old age. With its live (but attenuated) bacteria, BCG is thought to provide the most potent immune training, but other vaccines may also stimulate the body's defences.

Consider the flu jab. Nicola Veronese of the **University of Palermo** in Italy and her colleagues recently analysed the results of nine studies, many of which controlled for lifestyle factors, including income, education, smoking, alcohol consumption and hypertension.

The team found that the influenza vaccine was associated with a 29% reduced risk of dementia.

"Two studies also showed an association between the number of doses, over previous years, and the incidence of dementia," says Veronese.

Such studies still cannot prove causality.

The clinching evidence would come from a randomised controlled trial in which patients are either assigned the active treatment or the placebo. Since dementia is very slow to develop, it will take years to collect enough data to prove that BCG – or any other vaccine – offers the expected protection from full-blown Alzheimer's compared with a placebo.

New Alzheimer's weapon .....continue to page 34

Meanwhile, scientists have started examining certain biomarkers that show the early stages of disease. Until recently, this was difficult to do without expensive brain scans, but new experimental methods allow scientists to isolate and measure levels of amyloid beta proteins in blood plasma, which can predict a subsequent diagnosis with reasonable accuracy.

A pilot study by Coad Thomas Dow of the **University of Wisconsin-Madison** and his colleagues suggests that BCG injections can effectively reduce plasma amyloid levels, particularly among those carrying the gene variants associated with a higher risk of Alzheimer's.

Although the sample size was small – just 49 participants in total – it has bolstered hopes that immune training will be an effective strategy for fighting the disease.

Weinberg has his own grounds for optimism. Working with Dr Steven Arnold and Dr Denise Faustman, he has collected samples of the cerebrospinal fluid that washes around the central nervous system of people who have or have not received the vaccine.

Their aim was to see whether the effects of trained immunity could reach the brain, whicj is exactly what they found. "The response to pathogens is more robust in specific populations of these immune cells after BCG vaccination," says Weinberg..

"The BCG vaccine is safe and globally accessible," he adds. It is also cheap compared with the other options, and even it confers just a tiny bit of protection, "It wins the cost-effectiveness contest hands down."

As Calmette and Guérin discovered with their potato slices more than a century ago, progress may come when you least expect it.

GLP-1 AGONISTS FOR OBESITY—A NEW RECIPE FOR SUCCESS?

February 29, 2024
GLP-1 Agonists for Obesity—A New Recipe for Success?
Dariush Mozaffarian, MD, DrPH1,2
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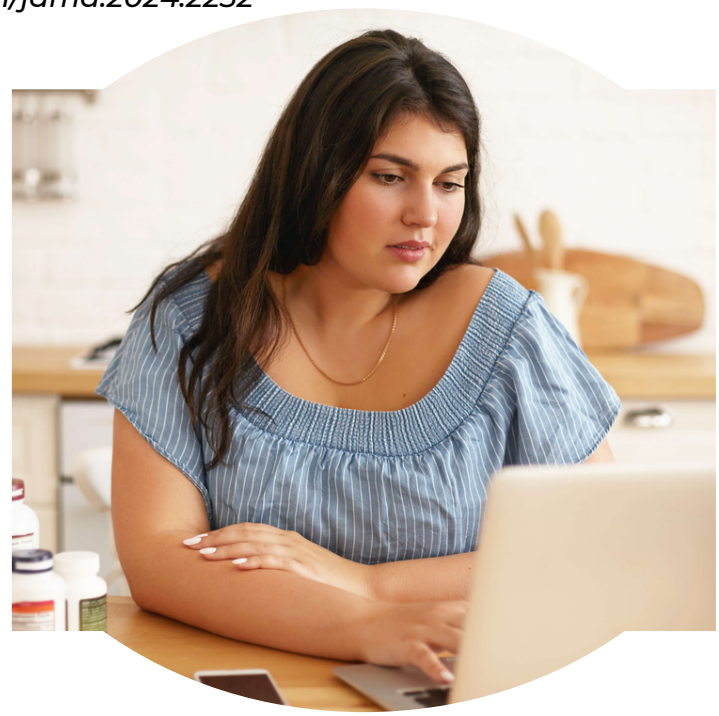
With ever-rising global adiposity, glucagon-like peptide 1 (GLP-1) agonists are shifting the treatment landscape. In trials, GLP-1 agonists produce placebo-adjusted weight loss of 12% to 18%—exceeding any prior pharmacologic therapy and generating enormous attention and utilization. From 2021-2023, the stock price of 2 manufacturers, Novo Nordisk and Eli Lilly, more than tripled, with a combined valuation now greater than $1 trillion.



Yet clinical and public confusion exists around real-world costs, tolerability, and access. One-half of US adults are interested in taking a prescription weight-loss drug,1 and 93 million meet GLP-1 weight-loss eligibility criteria.2 US list prices are $12 000 to $16 000 per year; even with maximum negotiated discounts, costs will likely exceed $6500 per year. If all eligible US adults received GLP-1 agonists at discounts, the annual cost would be $600 billion—equal to all other US prescription drug spending combined. There are hopes that competition will lower prices, but each GLP-1 agent is protected by approximately 20 patents, many to 2040 or beyond.3 Even if current prices decrease, experience with other major drug classes suggests that newer agents in this class will be introduced, with incremental benefits but continuing high prices and aggressive marketing, making it unlikely that total costs will meaningfully decrease soon

In trials establishing efficacy for GLP-1 agonists, weight loss plateaus by 12 to 18 months. And, if the drug is stopped, patients generally regain the lost weight within a year—leading to recommended chronic use. For payers, this creates a cost-prohibitive scenario. Weight loss occurs early but then plateaus, with years of continuing treatment required just to maintain initial benefits.

This explains why, even with health benefits and discounted prices, these agents are not cost-effective, with incremental costs of $237 000 to $483 000 per quality-adjusted life-year.4 Consequently, even accounting for health benefits, GLP-1 agonists substantially increase costs. In one analysis, total annual health care costs among patients adherent to the drug doubled, from approximately $13 000 per person before starting the drug to $26 000 after.5.

Real-world long-term tolerability is also low. In one large analysis, only 27% of patients prescribed GLP-1 agonists were adherent after 1 year.5

Because lost weight is commonly regained after the drug is discontinued, this creates an additional vexing conundrum for payers: the major initial investment for therapy may be unwarranted if most patients eventually stop taking the drug and simply regain weight. And access to GLP-1 agents remains inequitable by race and ethnicity, income, and payer.6

GLP-1 Agonists for Obesity .....continue to page 37

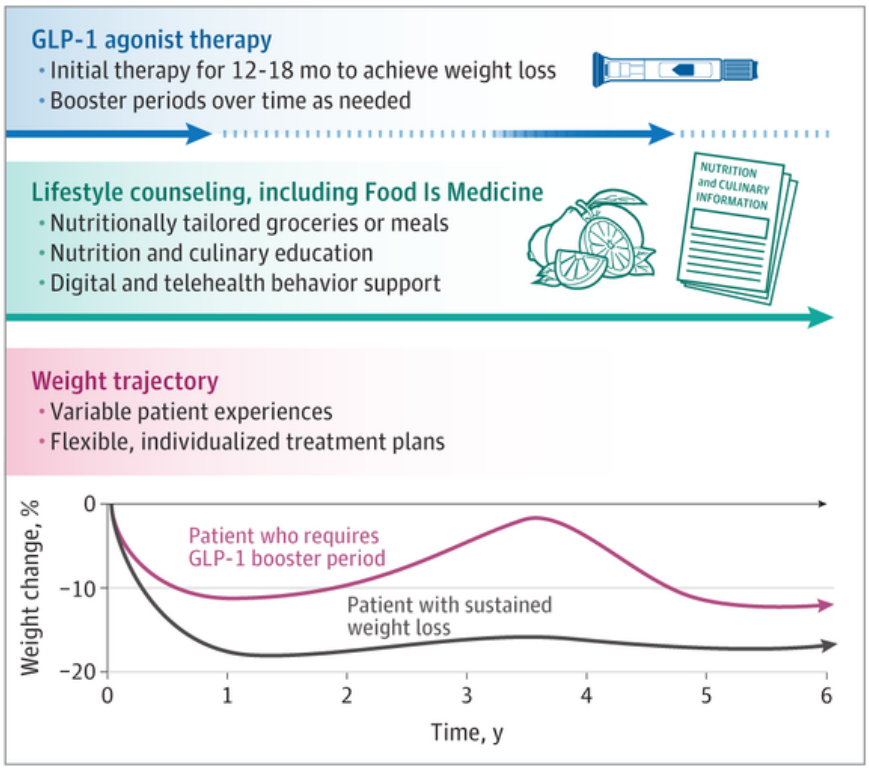
These issues of high price, low cost-effectiveness, and poor long-term adherence loom large to payers, clinicians, and patients. Widespread efforts are aiming to identify alternatives,7 such as rationing of GLP-1 agonists (or noncoverage). Some programs are combining older, less expensive weight-loss drugs (such as phentermine/topiramate or bupropion/naltrexone, which produce placebo-adjusted weight loss of 4%-5%4) with dietary coaching, given the foundational role of nutrition. Such programs reduce costs but may underdeliver. Older drugs produce small effects on weight, and coaching alone often produces only modest dietary change, especially when structural barriers are present like inadequate finances, limited transportation, or other social needs.

Patients, clinicians, and payers face a dilemma: an initially effective but costly, difficult-to-sustain program of chronic GLP-1 agonist use, vs a less costly but less effective strategy of older drugs plus behavioral coaching. Combining GLP-1 agonist therapy with lifestyle may produce larger benefits than either alone,8 yet a combined approach alters neither the long-term challenges of GLP-1 cost or adherence nor the structural inequities of lifestyle counseling approaches. And while rationing GLP-1 agonists reduces costs, it withholds from many patients the substantial short-term weight loss achievable with these agents.

In the face of this dilemma, an alternative solution can be considered: a new paradigm of initial, staged GLP-1 agonist treatment supported by long-term lifestyle programming that addresses structural barriers.

Given the critical role of nutrition, this means not merely supplying advice but providing healthy food: a Food Is Medicine (FIM) approach using medically appropriate groceries or meals. Such a program should include efficient guidance and tracking around nutrition, cooking, exercise, and sleep, leveraging telehealth, apps, peer support, artificial intelligence, and gamification. In this proposed paradigm, all eligible patients would receive GLP-1 agonists plus the FIM program. At 12 to 18 months, planned cessation of GLP-1 agonists would occur, with continued FIM programming for weight maintenance (Figure).

Figure. Combined, Staged GLP-1/FIM Approach to Obesity Treatment

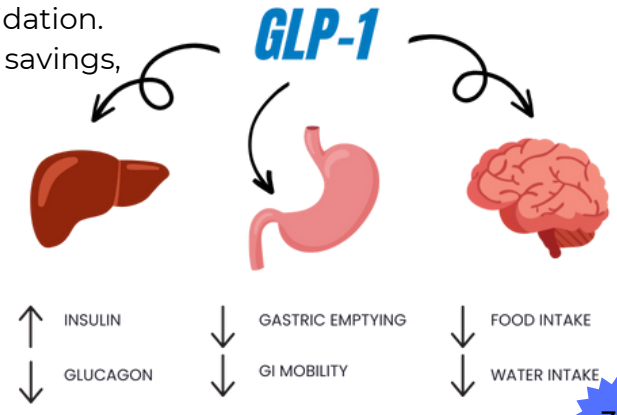


GLP-1 Agonists for Obesity .....continue to page 38

This proposed, testable program combines and leverages the complementary strengths of glucagon-like peptide 1 (GLP-1) agonists, lifestyle counseling, and Food Is Medicine (FIM). Initial GLP-1 agonist use could achieve substantial early weight loss, followed by long-term FIM programming and behavioral support for healthier eating, lifestyle, and sustained weight maintenance. A flexible, individualized treatment program would include potential booster periods of GLP-1 agonist use as needed. This combined strategy leverages (1) GLP-1 agonists' effective initial weight reduction while minimizing challenges of long-term tolerability and costs and (2) the benefits of FIM for addressing structural barriers around healthier eating while also amplifying its otherwise modest weight and health effects. This combined program may also advance equity in obesity management by reducing total treatment costs and directly supporting better nutrition and lifestyle through provision of food. The bottom panel depicts experiences of 2 hypothetical patients: one who achieves sustained weight loss after initial GLP-1 agonist use (black line) and another in whom FIM slows weight regain but requires booster GLP-1 agonist use at 3.5 years (purple line). The challenges of high price, low cost-effectiveness, and high attrition of GLP-1 agonists, together with the summed evidence on benefits of nutrition, behavioral counseling, and FIM, provide a compelling rationale to design and test this proposed intervention in carefully conducted trials.

Long-term trials like the Diabetes Prevention Program, PREDIMED, and CORDIOPREV demonstrate clinical efficacy of good nutrition. Controlled trials further support clinical benefits of structured nutritional counseling.9 Yet maintaining healthy habits can be difficult, especially for marginalized populations facing structural barriers. Accordingly, a key innovation and insight is to address structural impediments to long-term weight maintenance with clinically prescribed, medically appropriate food. This enhances patient adherence and health equity, reducing obstacles around cost, access, knowledge, and (when home-delivered) time and transportation. Quasi-experimental studies and some, though not all, randomized trials support benefits of FIM on diet quality, food security, cardiometabolic risks, disease self-management, and self-reported physical and mental health.10 Some FIM treatments associate with modest body mass index reductions of 0.4 to 0.6.10 These programs generally did not focus on weight loss or exercise: a FIM program integrating these features and designed expressly for weight maintenance could be quite effective.
A combined GLP-1 agonist/FIM program should be individualized (Figure). For some patients, the initial weight loss may be sustained long-term with FIM and its associated lifestyle support. In others, the program might only slow weight regain, requiring an episodic GLP-1 agonist "booster period." Undoubtedly, sustained weight loss will remain a challenge for others—ideally, a shrinking subset as experience combining GLP-1 agonists and FIM grows.

Current evidence from studies of nutrition, behavioral counseling, and FIM, together with mounting costs of GLP-1 agonists, justifies the investment to test this proposed program. FIM grocery programs typically cost $50 to $150 per month, and meal programs, $250 to $350 per month; the optimal combination of groceries and/or meals would require elucidation.
Even with telehealth or digital behavioral support, the net savings, tolerability, and efficacy of a staged GLP-1 agonist/FIM program could be much greater than GLP-1 agonist use alone, producing cost-effectiveness—or even cost savings . For example, if this treatment maintained weight loss in 500 patients who have discontinued GLP-1 agonists, drug savings would exceed $4 million per year. This program could also advance health equity in obesity treatment by addressing financial, educational, and access barriers to nutrition.



Reduce clinician burnout .....continue to page 39

With development of GLP-1 agonist/FIM programs, might effective, cost-effective, and equitable obesity treatment be within reach? Or is the hope too large and the challenge too great? These questions can only be answered through rigorous testing of staged GLP-1 agonist/FIM approaches. At a time when clinical and public perspectives on GLP-1 agonists oscillate between positive and negative hyperbole, but with real challenges of cost, long-term tolerability, and equitable access—and when FIM shows early promise to improve nutrition-related disparities—it is time to combine and test these advances in a new paradigm that might start to curb the health, equity, and cost burdens of obesity.

Article Information

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References

1.Montero A, Sparks G, Kirzinger A, Valdes I, Hamel L. KFF Health Tracking Poll July 2023: the public's views of new prescription weight loss drugs and prescription drug costs. Kaiser Family Foundation. Published August 4, 2023. Accessed December 12, 2023. https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-july-2023-the-publics-views-of-new-prescription-weight-loss-drugs-and-prescription-drug-costs/
2.Wong ND, Karthikeyan H, Fan W. US population eligibility and estimated impact of semaglutide treatment on obesity prevalence and cardiovascular disease events. Cardiovasc Drugs Ther. Published online August 14, 2023. doi:10.1007/s10557-023-07488-3PubMedGoogle ScholarCrossref
3.Alhiary R, Kesselheim AS, Gabriele S, et al. Patents and regulatory exclusivities on GLP-1 receptor agonists. JAMA. 2023;330(7):650-657.
ArticlePubMedGoogle ScholarCrossref
4.Atlas SJ, Kim K, Nhan E, et al. Medications for obesity management: effectiveness and value. J Manag Care Spec Pharm. 2023;29(5):569-575.PubMedGoogle Scholar
5.Prime Therapeutics. Real-world analysis of GLP-1a drugs for weight loss finds low adherence and increased cost in first year. Published 2023. Accessed July 30, 2023. https://www.primetherapeutics.com/news/real-world-analysis-of-glp-1a-drugs-for-weight-loss-finds-low-adherence-and-increased-cost-in-first-year/
6.Eberly LA, Yang L, Essien UR, et al. Racial, ethnic, and socioeconomic inequities in glucagon-like peptide-1 receptor agonist use among patients with diabetes in the US. JAMA Health Forum. 2021;2(12):e214182. doi:10.1001/jamahealthforum.2021.4182
ArticlePubMedGoogle ScholarCrossref
7.Virta Health. Results from new executive survey on GLP-1s and lifestyle intervention programs: how health plan leaders are handling the GLP-1 cost crisis. Published 2023. Accessed November 29, 2023.
https://s3.amazonaws.com/assets.virtahealth.com/docs/Virta_GLP-1-Obesity-Survey-Report.pdf
8.Lundgren JR, Janus C, Jensen SBK, et al. Healthy weight loss maintenance with exercise, liraglutide, or both combined. N Engl J Med. 2021;384(18):1719-1730. doi:10.1056/NEJMoa2028198PubMedGoogle ScholarCrossref
9.Low JHM, Toh DWK, Ng MTT, et al. A systematic review and meta-analysis of the impact of different intensity of dietary counselling on cardiometabolic health in middle-aged and older adults. Nutrients. 2021;13(9):2936.PubMedGoogle ScholarCrossref
10. Mozaffarian D, Aspry KE, Garfield K, et al. "Food Is Medicine" strategies for nutrition security and cardiometabolic health equity. J Am Coll Cardiol. 2024;83(8):843-864.PubMedGoogle ScholarCrossref

THE ROLE OF DEXLANSOPRAZOLE MODIFIED RELEASE IN THE MANAGEMENT OF GORD

Uncover the role of Proton Pump Inhibitors, specifically the innovative Dexlansoprazole, in managing GORD, and understand its significant impact on patients' quality of life.

Erosive oesophagitis, caused by gastroesophageal reflux, is a common medical problem. Therapy for erosive oesophagitis primarily focuses on the pharmacological reduction of gastric acid secretion. Decreasing the acidity of gastric juice improves reflux symptoms and facilitates oesophagitis healing.2

Gastro-oesophageal reflux disease (GORD) is associated with considerable reductions in quality of life and work productivity, as well as increased healthcare use. Proton pump inhibitors (PPIs) are currently the most effective treatment for GORD. However, there are limitations associated with these drugs in terms of patients' response.1

PROTON PUMP INHIBITORS

The PPI, introduced in 1989, targeted the gastric H+, K+-ATPase and reflected a major medical therapeutic breakthrough in the treatment of peptic ulcers and GORD, resulting in more rapid healing of the lesions and symptom relief.10 A PPI is a prodrug which is activated by acid. Activated PPI binds covalently to the gastric H＋, K＋ -ATPase via disulfide bond. Cys813 is the primary site responsible for the inhibition of acid pump enzyme, where PPIs bind.3

PPIs have about one hour of elimination half-life. The area under the plasmic concentration curve and the intragastric pH profile are very good indicators for evaluating PPI efficacy. Though CYP2C19 and CYP3A4 polymorphism are major components of PPI metabolism, the pharmacokinetics and pharmacodynamics of PPIs depend on the CYP2C19 genotype status.4

Omeprazole was the first PPI introduced in market, followed by pantoprazole, lansoprazole and rabeprazole. Though these PPIs share the core structures benzimidazole and pyridine, their pharmacokinetics and pharmacodynamics are a little different. Several factors must be considered in understanding the pharmacodynamics of PPIs, including:

- Accumulation of PPI in the parietal cell
- The proportion of the pump enzyme located at the canaliculus
- De novo synthesis of new pump enzyme
- Metabolism of PPI
- Amounts of covalent binding of PPI in the parietal cell
- The stability of PPI binding.4

Dexlansoprazole .....continue to page 42

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References: 1. TADALAFIL ADCO Professional Information. October 2022. 2. Gong B, Ma M, Xie W, *et al.* Direct comparison of tadalafil with sildenafil for the treatment of erectile dysfunction: a systemic review and meta-analysis, *Int Urol Nephrol* 2017;49:1731-1740.

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S-omeprazole is relatively insensitive to CYP2C19, so better control of the intragastric pH is achieved. Similarly, R-lansoprazole was developed to increase the drug activity. Delayed-release formulation resulted in a longer duration of effective concentration of R-lansoprazole in blood, in addition to metabolic advantage. Dexlansoprazole showed best control of the intragastric pH among the present PPIs. Overall, PPIs made significant progress in the management of acid-related diseases and improved health-related quality of life.4

CELLULAR MECHANISM OF PROTON PUMP INHIBITORS IN THE STOMACH

In the human body, the only acidic space below pH 4 is the stomach. With the realisation that these PPIs are weak bases with a pKa between 4 (omeprazole, lansoprazole and pantoprazole) and 5 (rabeprazole), it was clear that they would accumulate in the acidic space of the secretory canaliculus of the stimulated parietal cell.4

This acid space dependent concentration of the PPIs is their first important property that determines their therapeutic index, giving a concentration at the luminal surface of the pump that is about 1000-fold of that in the blood. The second vital step is the low pH dependent conversion from the accumulated prodrug to the activated species that is a highly reactive cationic thiophilic reagent. This means that protonation of these compounds is required for their activation to form disulfides with cysteines of the H+, K+-ATPase.4

The presence of acid secretion is necessary for PPI action. It is recommended that they be given 30 minutes before a meal to ensure that the pumps are active when peak concentrations of the PPIs are present in the blood. It is also necessary to protect them from gastric acid prior to absorption.4

Because PPIs have a relatively short half-life and not all pumps are activated, it takes about three days to reach steady state inhibition of acid secretion as a balance is struck between covalent inhibition of active pump, subsequent stimulation of inactive pumps after the drug has been eliminated from the blood and de novo synthesis of new pumps.4

The target for treatment of many acid-related disorders is reduction of gastric acid secretion. Proton pump inhibitors (PPIs) are widely used to reduce acid secretion in patients with GORD.1

PPIs inhibit the secretion of hydrogen ions in the stomach by inhibiting the (H+,K+) -ATPase enzyme (proton pump) at the secretory surface of the gastric parietal cell, resulting in potent inhibition of gastric acid secretion with prolonged elevation of intragastric pH.3

CLINICAL LIMITATIONS

While PPIs are widely regarded as the gold-standard of GORD treatment, there are several clinical limitations to some PPIs. PPIs are associated with limited ability to fully relieve the discomfort of GORD, particularly at night.

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Studies show that only 23% of patients felt that their pain and discomfort was completely controlled with PPIs at night and 94% continued to experience breakthrough symptoms.

This resulted in 49% of respondents using adjunctive medications to control discomfort. In particular, 45% of respondents found that treatment for nocturnal pain was unsatisfactory. Approximately 38% of patients taking PPIs had breakthrough symptoms, and an overwhelming 65% of these patients experienced them at night.1

According to Goh et al (2016), "The active ingredient in a PPI must be present in high concentrations when the proton pumps are stimulated before and during a meal. As PPIs are acid labile, they need protection from degradation in the stomach by enteric coating or buffering. PPIs are rapidly absorbed and subsequently eliminated, leading to a short plasma half-life and ultimately restricting their administration to before meals to achieve their full effect."1

As pre-meal dosing is not always convenient, this may lead to poor adherence. However, participants reported good adherence to the prescribed therapies in terms of frequency of administration (87%), timing of medication (87%), and mealtimes (88%).1

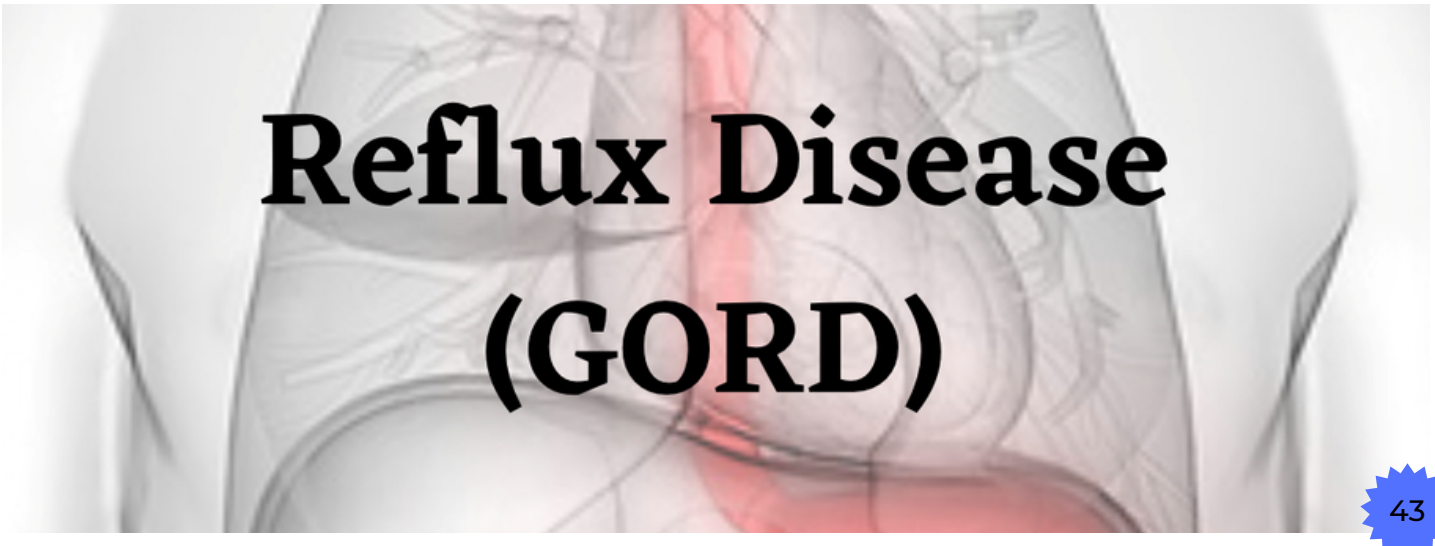
DEXLANSOPRAZOLE

Dexlansoprazole is the R-enantiomer of the PPI lansoprazole, a racemic mixture of R-lansoprazole and S-lansoprazole. The R-enantiomer is associated with 3-5 times greater maximum concentration (Cmax), area under the plasma concentration-time curve (AUC), and time to maximum concentration values than the S-enantiomer, and smaller total body clearance values, so it has greater systemic exposure than lansoprazole and a longer elimination half-life than S-lansoprazole.1

Dexlansoprazole is the first PPI with a dual delayed release formulation designed to provide two separate releases of medication to extend the duration of effective plasma drug concentration. Dexlansoprazole has been shown to be effective for healing of erosive oesophagitis, and to improve patient well-being by controlling 24-hour symptoms.

Dexlansoprazole has also been shown to achieve good plasma concentration, regardless of administration with or without food, providing flexible dosing.1 The dual delayed release formulation of dexlansoprazole results in a plasma concentration-time profile with two peaks.

The pharmacodynamic impact of the second peak is that PPIs work only on activated H+, K+-ATPase enzyme (proton pumps), of which 70%-80% are activated after a meal, leaving 20%-25% inactivated. These can still be activated and lead to acid secretion. Additionally, these proton pumps have a half-life of about 50 hours, meaning that approximately 25% of the pumps are produced daily at approximately 1% per hour. These newly produced H+, K+-ATPase enzyme (proton pump) can then also produce acid.



Dexlansoprazole .....continue to page 44

DUAL DELAYED RELEASE FORMULATION

Experts do agree on one thing: We can do more to help people who are struggling. "It's very good that people are having discussions around tempering consumption because we clearly have a serious drug and alcohol addiction, obesity, and digital media problem," said Lembke.

Dexlansoprazole is a novel formulation that employs a dual delayed release technology designed to prolong the concentration-time profile and provide an extended duration of acid suppression.1
The dual delayed release technology uses two types of enteric-coated granules with different pH-dependent dissolution profiles to provide an initial drug release in the proximal small intestine, at a pH of approximately 5.5, followed several hours later by another drug release at more distal regions of the small intestine, at a pH of ≥6.75. Dexlansoprazole therefore produces a dual-peaked pharmacokinetic profile, as opposed to the single peak seen with conventional PPIs.

Dexlansoprazole increases the mean intragastric pH and the duration that intragastric pH is >4 over a 24-hour period. The optimal dose range is 30-90mg, and the two doses currently approved for clinical use are 30mg and 60mg.1

Dexlansoprazole is the first PPI with a dual delayed release formulation designed to provide two separate releases of medication. In January 2009, the FDA approved dexlansoprazole for the treatment of heartburn associated with symptomatic non-erosive GORD, healing of erosive esophagitis (EE) and maintenance of healed EE at doses of 30mg and 60mg once daily.1

24-HOUR CONTROL

The factors involved in successful treatment of GORD include acid suppression, duration of suppression over the 24-hour period, and duration of treatment. Suppression of gastric acid secretion by PPIs is at its greatest when proton pumps are the most active. It has been established that PPIs are the most effective therapy for patients with GORD. PPIs are also given in conjunction with non-steroidal anti-inflammatory drugs (NSAIDs) for patients with risk factors for upper gastrointestinal bleeding, and for acid suppression in the regimen for Helicobacter pylori eradication.1

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Chiang et al (2019) compared the clinical efficacy of single doses of dexlansoprazole (modified-release 60mg) and esomeprazole (40mg) after 24-weeks follow-up in patients with mild erosive oesophagitis. Patients displaying complete symptom resolution (CSR) by the end of initial treatment (eight weeks) were switched to on-demand therapy until the end of 24 weeks.2

The GERDQ scores at 4-, 8-, 12-, 16-, 20-, and 24-week posttreatment were less than the baseline score. The CSR, rate of symptom relapse, days to symptom resolution, sustained healing rate of erosive esophagitis, treatment failure rate, and the number of tablets taken in 24 weeks were similar in both groups. The esomeprazole group had more days with reflux symptoms than the dexlansoprazole group (37.3±37.8 vs 53.9±54.2; P=0.008). In the dexlansoprazole group, patients exhibited persistent improvement in the GERDQ (a validated questionnaire) score during the on-demand period (week 8 vs week 24; P<0.001) but not in the esomeprazole group (week 8 vs week 24; P=0.846).2

This study suggests that the symptom relief effect for GERD after 24 weeks was similar for dexlansoprazole and esomeprazole. Dexlansoprazole exhibited fewer days with reflux symptoms in the 24-week study period, with better persistent improvement in the GERDQ score in the on-demand period.2

CONCLUSION

Since PPIs were introduced, considerable progress has been made in the management of acid-related diseases. The intragastric target pH can be maintained above the threshold level of >3 (peptic ulcer) or >4 (GORD) by PPIs. Specific enantiomers such as S-omeprazole and R-lansoprazole had significant advantage over the CYP2C19 enzyme. Better control of the intragastric pH was achieved by this specific enantiomer.4
Though the shape of the plasma concentration curve or the peak level was of minor importance, AUC was relatively linear fit with the antisecretory inhibition. Good linearity was observed between the amounts of PPI binding and the inhibition. Measuring the intragastric pH and AUC is enough to judge the drug efficacy. DR or ER of the drug enabled the night-time pH control due to prolonged time of effective plasma concentration.4
In patients with GORD, standard doses of esomeprazole and dexlansoprazole maintain intragastric pH above 4 for significantly longer periods compared with standard doses of other PPIs after five days of treatment. PPI treatment in GORD has been reported to result in the improvement of health-related quality of life.4

REFERENCES

1. **Goh KL, Choi MG, Hsu PI, Chun HJ, Mahachai V, Kachintorn U, Leelakusolvong S, Kim N, Rani AA, Wong BC, Wu J, Chiu CT, Shetty V, Bocobo JC, Chan MM, Lin JT**. Pharmacological and Safety Profile of Dexlansoprazole: A New Proton Pump Inhibitor - Implications for Treatment of Gastroesophageal Reflux Disease in the Asia Pacific Region. J Neurogastroenterol Motil. 2016 Jul 30;22(3):355-66. doi: 10.5056/jnm15150. PMID: 26932927; PMCID: PMC4930293.
2. **Chiang HH, Wu DC, Hsu PI, Kuo CH, Tai WC, Yang SC, Wu KL, Yao CC, Tsai CE, Liang CM, Wang YK, Wang JW, Huang CF, Chuah SK**; Taiwan Acid-Related Disease Study Group. Clinical efficacy of 60-mg dexlansoprazole and 40-mg esomeprazole after 24 weeks for the on-demand treatment of gastroesophageal reflux disease grades A and B: a prospective randomized trial. Drug Des Devel Ther. 2019 Apr 26;13:1347-1356. doi: 10.2147/DDDT.S193559. PMID: 31118571; PMCID: PMC6499145.
3. **Kukulka M, Eisenberg C, Nudurupati S**. Comparator pH study to evaluate the single-dose pharmacodynamics of dual delayed-release dexlansoprazole 60 mg and delayed-release esomeprazole 40 mg. Clin Exp Gastroenterol. 2011;4:213-20. doi: 10.2147/CEG.S24063. Epub 2011 Sep 14. Erratum in: Clin Exp Gastroenterol. 2011;4:255. PMID: 22016582; PMCID: PMC3190289.
4. **Shin JM, Kim N**. Pharmacokinetics and pharmacodynamics of the proton pump inhibitors. J Neurogastroenterol Motil. 2013 Jan;19(1):25-35. doi: 10.5056/jnm.2013.19.1.25. Epub 2013 Jan 8. PMID: 23350044; PMCID: PMC3548122.

URGENT REMINDER - Payment of HPCSA Registration Fees

Health Professions Council of South Africa

Dear Shareholders and Members,

You are reminded that the Annual Fees for registration with HPCSA are due. The due date is the **1st of April 2024.**
BUT PREFERABLY PAY BEFORE 30 March

The fees for 2024 – 2025 (this figure include VAT) are as follows:

MP	MEDICAL PRACTITIONER	R 3 178.00
MP	MEDICAL PRACTITIONER (SPECIALIST)	R 3 222.00
DP	DENTIST	R 3 178.00
PT	PHYSIOTHERAPIST	R 1 781.00
OT	OCCUPATIONAL THERAPIST	R 1 812.00

'Exemption from paying the annual fee may be granted from the year in which you turn 71, **IF you turn 71 before 01 April 2023'.**
PLEASE DO NOT just stop paying! On your profile on the HPCSA website there is a box: 'My Registrations' > 'Age Exception' > 'Upload supporting documents'.

Bank Details for EFT:
Bank: ABSA
Account name: HPCSA
Branch: Arcadia
Branch code: 632005
Account #: 405 00 33 481
Account Type: Cheque
Ref: 'Your full registration No.' (for example: MP1234567)

Payments can be done via EFT / as a direct deposit at the bank / on line: www.hpcsa.co.za

Urgent Reminder .....continue to page 47

Please note: Internet transfers take approximately three days to reflect on our statement and all direct payments from Absa branches take 24 hours.

Practitioners can do their HPCSA registration online by following the steps below. The platform enables practitioners to access their statements, invoices, new Electronic QR code practising card, applications for voluntary erasure, exemptions and the update of contact details.

How to register for HPCSA portal

1. Visit www.hpcsa.co.za clicking on the 'Online registration' tab in the navigation bar.
2. Create an HPCSA account by entering your 13-digit ID number or passport number.
3. Using your ID Number as the Username and Password created in Step 1, LOGIN and Renew. This also allows you to edit you're your personal details – see Notes on Practicing Card below.
4. You can now make your annual payment through Credit or Debit Card or Integrated EFT or Bank Deposit
5. Access the HPCSA Practicing Card – electronically or print out.

Assistance
Practitioners can contact the HPCSA Client Care Centre for assistance with any aspect on their online registration at **(+27) 12 338 9300/01** or **info@hpcsa.co.za**

E-mail proof of payment to: **info@hpcsa.co.za**

PLEASE KEEP YOUR RECEIPTS OF PAYMENT & POSTING

How Do Doctors Feel About Assisted Dying?

Public attitudes to assisted dying appear to be changing, but what do doctors think? If there's a change in the law, it will be doctors who are prescribing or administering life-ending medication.

Dr Aneez Esmail is a Royal College of GPs council member. He has 30 years of experience as a GP and is also Emeritus Professor of General Practice at the University of Manchester.

He believes that doctors' views on assisted dying are, indeed, changing. "Without a doubt they are, and partly we are being driven by the public on this. What I've found is patients are more willing to have the discussion, which has made doctors more willing to talk about it."

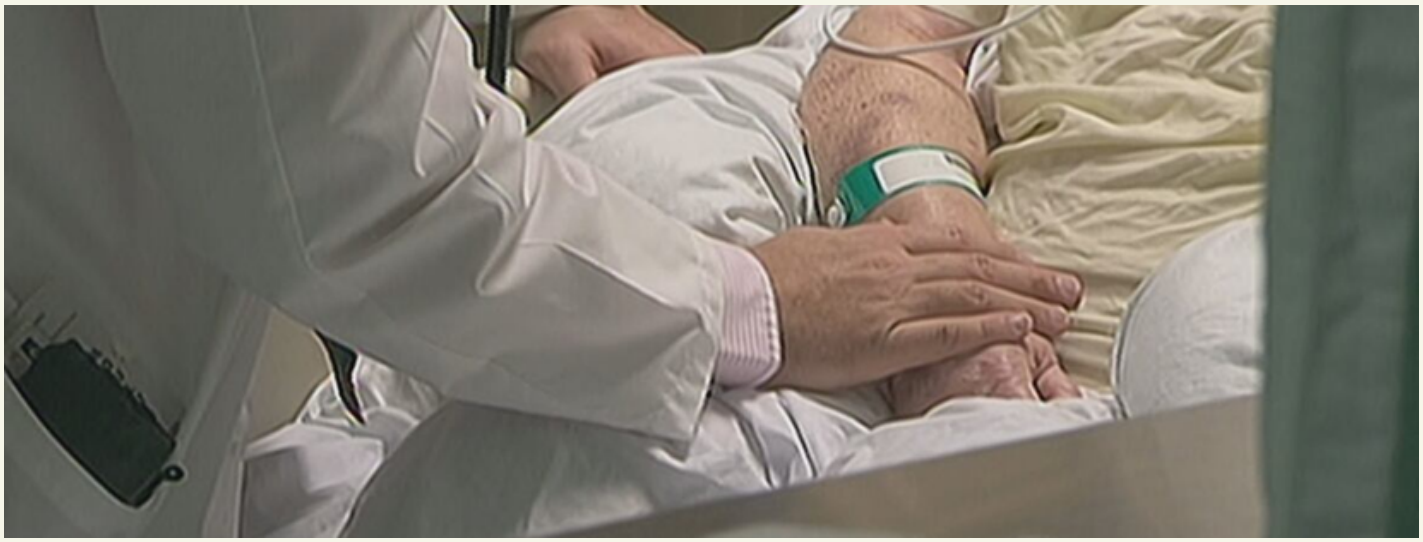
Assisted dying has recently been high on the UK news agenda. Several celebrities, most notably Dame Esther Rantzen, have been sharing their support for it. The Daily Express and Dignity in Dying have started a petition to support Dame Esther's call for a parliamentary debate. To date, it has more than 120,000 signatures. Also, parliament's Health and Social Committee is due to publish its long-awaited report into assisted dying early this year.

Two-Thirds of the Public Support Assisted Dying

A recent poll in 2023 found that 65% of people in the UK think it should be legal for a doctor to assist an adult of sound mind and with less than 6 months to live to voluntarily end their own life. It also found that 61% of people believe it should be legal for a doctor to administer life-ending medication.

Assisted dying proposals are currently being debated in Scotland, the Isle of Man, and Jersey. Medically assisted dying is legal in Canada, the Netherlands, Switzerland, Belgium, and some US and Australian states.

How Do Doctors Feel .....continue to page 49



What Do Doctors Think?

The British Medical Association changed its position on physician-assisted dying in 2021. It had been opposed to it but now takes a neutral stance. The move followed an extensive survey of its members.

It found 50% of doctors would like a change in the law to allow physicians to prescribe life-ending medication for terminally ill adults of sound mind with less than 6 months to live, to administer themselves. 39% were opposed to a change in the law and 11% were undecided. When it came to a doctor administering the life-ending medication, 37% supported it, 46% were opposed, and 17% were undecided.

The Royal College of Physicians also takes a neutral stance on the issue. Its last survey in 2020 asked members and fellows if they would support a change in the law on assisted dying. 40.5% said they would, while 49.1% said they wouldn't.

The Royal College of GPs continues to oppose assisted dying. However, in 2023 it gave the green light for a working group to be set up that would think through the practical implications should the law change.

Esmail, who is a board member of Dignity in Dying, believes the RCGP view is out of kilter. He told Medscape News UK: "No doctors' organisation should be opposed to assisted dying. Doctors need to be engaged in the debate, as we play a big part in looking after patients who are dying. It's not right that we should be cut out of these discussions."

Palliative Care Is Enough

Opponents say there is no need for it. "When we provide the highest quality of palliative care, there's no requirement for assisted suicide," explained Alistair Thompson, spokesperson for the campaign group Care Not Killing.

He told Medscape News UK that, when surveyed, "Those doctors who deal with people at end of life, palliative care, general practice, oncology, and trauma, they still oppose changing the law on assisted suicide. Whereas the doctors in other specialities, like adolescent mental health, dermatology, and occupational health were overwhelmingly in favour."

But Esmail doesn't share that view. He was originally opposed to assisted dying but changed his mind. He said: "Through my own experience of looking after my patients, I saw the limits of palliative care and it didn't always relieve suffering to the extent that would have benefited my patient. The public has led the way on this by saying we want to have more options available to us."

"We are talking about a very few numbers. It might only be 1% of all of the patients who are dying. It's only when palliative care fails or the patient says 'I don't want that anymore' that there would be that discussion," he added.

Safeguards

One of the arguments against assisted dying is that safeguards aren't strong enough. "There are some chilling case studies in places like Canada where safeguards are eroded over time and doctors are put under huge pressure to carry out in effect state-actioned killing of patients against their judgement," said Thompson.

He added: "In Canada, according to their own data, people are citing reasons like loneliness and inability to get social care as the reason for their choice to have a medically assisted death."

Doctors Could Opt Out

If a change in the law is ever allowed for assisted dying in the UK, it would never be compulsory for all doctors to agree on it in principle or for all doctors to carry it out. "Most of us who are for assisted dying are very clear that this is a personal choice, you shouldn't be forced to do anything. It's a bit like abortion, if you are opposed to it, you just direct your patient to someone else. That is the position we would develop with assisted dying," explained Esmail.

In all jurisdictions around the world where it is legal, doctors are not forced to implement it. "Doctors choose whether or not they want to be involved. I'm a GP and because I look after dying patients as part of my job, I would certainly be willing to help patients if the law allowed me to do so. But I also know some of my colleagues wouldn't. You shouldn't deny patients the option just because you are opposed to it," said Esmail.

Debate

It looks increasingly likely that MPs will debate assisted dying in the next parliament. Any proposed law would likely be brought as a Private Members' bill rather than by a political party.

Thompson welcomes any debate: "It's a really important issue, and afterwards we could move on to the more important issue of how we fund a system of palliative care that is under huge pressure."

Esmail said: "For far too long, people haven't wanted to talk about dying, as it's uncomfortable. But there needs to be much more honest discussion about giving people a good death."

HOW TO JOIN THE UNIVERSAL HEALTHCARE GENERAL PRACTITIONER NETWORK:

Medical Scheme Name	Option/Plans
CompCare Medical Scheme	Umbono Option (previously Networx Option)
	Umbono ED Option (previously NETWORX ED Option)
Massmart Health Plan	Network Option
	Essential Option
Old Mutual Staff Medical Aid Fund	Network Plan
	Network *SELECT* Plan
Tiger Brands Medical Scheme	Base Option
Transmed Medical Fund	Link Plan
Witbank Coalfields Medical Aid Scheme	Ntsika Option

Category	Category Description	2024 Fees (incl VAT)
Category A	**Dispensing doctors:** Consultation fee including acute medication	R496
Category B	**Non-dispensing doctors:** Consultation fee including acute medication dispensed by a Universal Network Pharmacy	R496
Category C	**Non-dispensing doctors:** Consultation fee excluding acute medication (consultations only)	R343

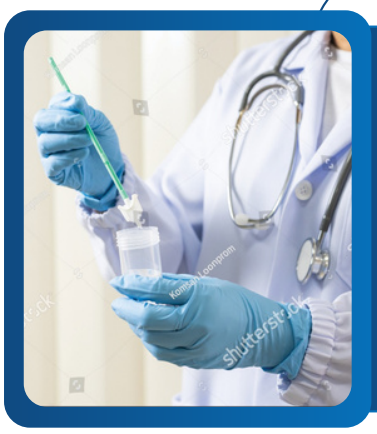
gems Government Employees Medical Scheme

GEMS CYTOLOGY TEST SCREENING BENEFIT FOR 2024

GEMS would like to thank all the healthcare providers for rendering healthcare services to its beneficiaries.

If you have any queries or wish to participate in the GEMS Provider Network,

- **Call us on 0860 436 777, weekdays between 08:00 and 17:00; or**
- **Send an email to enquiries@gems.gov.za.**



The Scheme has carefully reviewed the recommendations made by **healthcare providers regarding the Cytology Screening tests and is pleased to inform you of the enhancements made with effect from 01 January 2024. An in-house code 99385** (Sterile tray and specimen handling fee) has been created for Practice types 1415 and 16 only, across all benefit options. This is to be used in the place of the codes **0202 / 0210**, when claiming for the performance of the Cytology screening test. (taking pap smears).

DISCOVER THE BRILLIANCE OF GEMS

Contact details
086 043 6777
enquiries@gems.gov.za
www.gems.gov.za

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Government Employees Medical Scheme

Use the QR Code to download the **GEMS Provider App**

Google play App Store

The Government Employees Medical Scheme (GEMS) is an authorised Financial Services Provider (FSP No 52861)

Working towards a healthier you

Discovery CORNER

'Smart Plan': Additional information for Smart Plan Network
Members are covered for unlimited GP consultations (0190, 0191 and 0192) when visiting a GP in the Smart GP Network:

Classic Smart Plan
A R65 co-payment applies for each visit and the balance of the consultation fee will be covered up to the Discovery Health Rate.

Essential Smart Plan
A R120 co-payment applies for each visit and the balance of the consultation fee will be covered up to the Discovery Health Rate.

Essential Dynamic Smart Plan
A R120 co-payment applies for each visit and the balance of the consultation fee will be covered up to the Discovery Health Rate. Only the consultation will be paid. Any other healthcare costs will not be covered. This will need to be paid from the member's pocket.

Note: Any consultation from a non-network GP will need to be paid from member's own pocket.

Virtual consultations are done through the Discovery Health app or on the Discovery website platform.

SMART PLAN: As a healthcare funder, DH has a responsibility to its members to provide access to top quality healthcare, while ensuring the long-term sustainability of the scheme. For the Smart range specifically, our challenge is to achieve a balance between technology, affordability, benefits and quality care for our member's. We've had to ***establish criteria for practices who can both service our members efficiently, and benefit from doing so.***

For this reason, the Smart network is an invitation only network, with the invitation **extended only to practices that have demonstrated efficiency** on existing networks, and **with the existing electronic tools**, and that can make the maximum benefit from Smart enabled members.

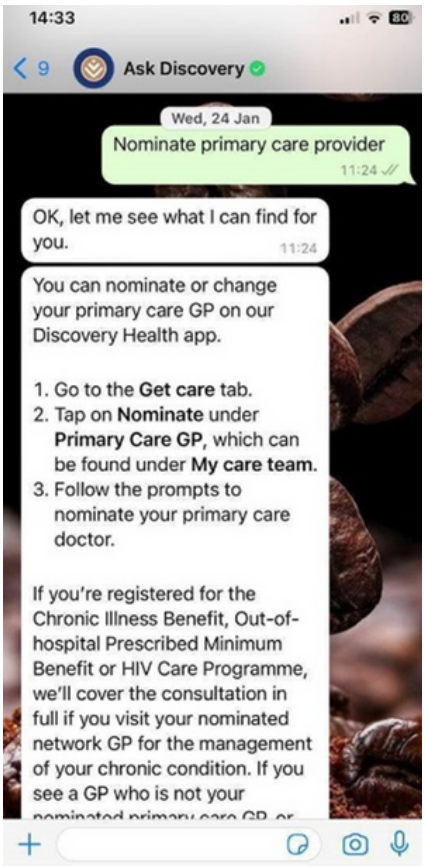
Ongoing review: **We *review the Network on an annual basis***, with the objective of ensuring that members continue to receive optimal standards of care, while maintaining the sustainability and affordability of the plan. *The current networks cannot accommodate. E.g.: in small towns.*

'NB: 'Primary Nomination' is ÓNLY available to members on Discovery Health Medical Scheme Plans and NOT our Administered Plans such as LA Health, Remedi, Bankmed, etc.

Discovery Corner .....continue to page 54

There is a 'WhatsApp' no. which DH patients can use to choose a 'Primary GP': 0860 756 756

The following example was sent by DH:



'CHRONIC PATIENTS':

Dr X: **'New chronic consultations must be with nominated GP**. I had to see a patient of my associate while he was on leave. The patient now has a R120.22 co-payment with me because I am not the 'nominated GP'. Discovery's system for making nominations was not operational during consultation. Patient is now unhappy & angry with me because she must make a co-payment with me and never with 'her' Dr. Had another case today where I was applying for a new patient for chronic - she had no nominated Dr yet and had a co-payment. GP's are not properly informed regarding the nomination process.

DH: **Associates with different practice numbers under the same roof IS a problem.**
Refering to chronic care: Patients should mention they are coming for chronic condition. If NOT, 20% co-payment if they see a different doctor in the practice. The member would need to be informed at the practice that if it is NOT serious, he/she should come back when their nominated Dr is there again.
Maybe put a note in practice that explains to patients that these are different Drs & they will have to pay an extra if they don't see nominated Dr.
Unfortunately, Group practices billing on Group number, it IS allowed with no co-payment.

'TESTS on HealthID / Diabetes shared-value model

Dr Y: 'You must capture the results for all three of the following tests on HealthID for 70% or more of your patients living with diabetes:

1. HbA1C (4064)
2. LDL (4026)
3. Serum creatinine (4032/4223) or microalbuminuria (4261/4262) "

- As to my knowledge all the laboratory tests done are automatically captured and reflected on your system routinely.
- The already onerous time-consuming administrative actions you require in accessing HealthID often fails for load shedding, is therefore severely time consuming, reduces the face to face intervention with the patient and I won't even dwell on the frustration factor it generates.
- The previous version of HealthID annotating only the biometric measurements were efficient and easy to comply with.
- Furthermore, you should clarify, w.r.t. the POPI act, the providers position in providing confidential information without the **"express"** consent of the patient, as required by the HPCSA. When I register a patient on HealthID I do so with the patient present providing **"express"** consent and it improves compliance.

***The question remains though why we should capture lab results when it has always happened directly + the POPI Act question re "express" consent also requires an answer.**

I am using the Health ID facility to register patients, but am reluctant to enter clinical information due to confidentiality while it does take at least an additional 10 minutes to complete IF the internet is working?'

DH:HealthID: If any data is lost can check back and capture later. Pull info through from the lab - you don't háve to override info from the lab. If there is a discrepancy, then an override can be done. Sometimes Drs are NOT happy with the lab results & prefer their own tests
Consent: If the patient has already given consent, this is sufficient.

'Practice Activity Tracker' Reports:
CPC/Qualicare needs an explanation on the 'Practice Activity Tracker' reports that some practices have recently received from DH. We have only recently been made aware of it. We will push for a full training session from DH and will then provide feedback to our practices.

Flexicare

- Flexicare preferably has to choose a Primary GP
- If they do go to another GP (ónly to a Dr on the Flexicare Network), DH will change 'this GP' as their primary GP
- If you as a doctor are the third doctor within a year, you will not be paid for your services

If a patient sees a GP for chronic conditions but they have not nominated a PCP then we will fund the chronic claim at **80% of the Discovery Health Rate**.

Primary Care Provider (PCP)
Members on KeyCare, TFG Health, LA KeyPlus and Smart plans must nominate a GP in their plan networks. Members on other plans can nominate any GP as their PCP. However, if a member wishes to have full cover for consultations/procedures related to their chronic conditions, network rules apply. Refer to the table below:

Plan/Scheme
GP PCP Designated Service Provider
Member is on a Care Programme
Premier Plus GP network (Network 208 and 90)
Comprehensive, Priority, Saver and Core plans
Discovery GP network (Network 352)
Smart plans
Smart GP network
KeyCare Plus
KeyCare GP network (Network 365)
KeyCare Start
KeyCare Start network (Network 330)
KeyCare Start Regional
Applicable KC Start Regional network (Network 535, 536, 537, 538, 539, 540 or 544)
LA KeyPlus
KeyCare GP network (Network 365)
TFG Health
KeyCare GP network (Network 365)

Note: Any consultation from a non-network GP will need to be paid from member's own pocket. However, we have identified instances where the system does not apply this rule for chronic patients but instead the claim partially pays. The system team is working to resolve the issue.

Chronic members
The designated service provider (DSP) for consultations and procedures is the PCP GP for members approved on the below:
·Chronic Illness Benefit (CIB)
·Out-of-hospital Prescribed Minimum Benefits (OHPMB)
·HIV Care Programme.

This will be covered up to 100% of the Scheme Rate.

We will only cover members' claims at 80% of the Discovery Health Rate in the following circumstances:
·If a member uses a GP that is not their nominated PCP
·If a member doesn't have a nominated PCP GP
·If a member has nominated and uses a GP that is not within the network for their plan.

With the exception of members on **KeyCare**, **TFG Health**, **LA KeyPlus** and Executive plans, members have access to one out-of-area chronic visit to a non-PCP GP per year, provided that the member has a nominated PCP in the plan network and that the non-PCP GP they consult is on the Discovery GP network. Chronic consultations are not usually emergencies, and therefore members must attempt to plan these consultations for when their PCP is available.

Non-chronic members
Members that are not flagged for CIB, OHPMB or HIV will be prompted to nominate a PCP GP in 2024, but the nomination process will not impact their benefits or cover. Normal plan type rules will apply for GP consultations or procedures.

Discovery Corner .....continue to page 57

Discovery Health Key Benefit Updates for 2024

Dear Qualicare Practice,

Kindly refer to the Information below on Key Benefit Updates on Discovery Health for 2024:

Key benefit updates for 2024.

GP PCP

Rationale

According to a recent World Health Organisation report, patients with chronic illnesses who use a single GP for the coordination of their long-term care had 27% fewer visits to the emergency department and 13% fewer hospital admissions. "75% patients prefer to see a single provider for coordinated care. 63% patients value seeing a provider that they know and trust."

Overview | Benefit | Update

Based on the significant opportunity to improve health outcomes, from 2024, all members registered for Prescribed Minimum Benefit chronic conditions will be required to nominate a primary care network GP for the management of their chronic illnesses for full cover for chronic conditions.
Members and their doctors will be supported through the nomination and management process through a range of easy-to-use digital tools.

Should a member with a registered chronic condition opt not to nominate a primary care network GP, or should a member voluntarily choose to consult a GP other than their nominated network GP, the Scheme will cover the consultation at 80% of the Discovery Health Rate.

Eligibility

Not applicable for members on Executive plan
Impacted members will receive communication on GP nomination process
KeyCare and Smart members must nominate a GP within their respective GP network
Nominated GPs can be changed 3 times per year

Funding

Co-payment does not apply for chronic conditions managed by specialists, prescribed chronic medicine or consultations relating to acute conditions
No co-payment required in emergencies or involuntary use of non-DSP
One out-of-area visit to a non-nominated primary care GP will be covered if the member has nominated their primary care GP

Hospital at Home

Overview

In 2021, Discovery launched Discovery Hospital at Home to provide patients with home-based hospital care for conditions that can safely and effectively be treated while the patient remains at home.

The experience to date has shown that hospital level care can be delivered safely in a home-setting for a range of clinically appropriate conditions, with similar or superior health outcomes compared to traditional in-hospital care.

The experience to date has shown that hospital level care can be delivered safely in a home-setting for a range of clinically appropriate conditions, with similar or superior health outcomes compared to traditional in-hospital care.

Home Monitoring Kit

Care is unaffected by connectivity constraints and loadshedding. A home monitoring kit is delivered to a patient within 2 to 4 hours of admission and is supplied to the patient for the duration of the admission. The kit includes:

- A wearable monitoring device,
- UPS backup for charging
- A Smartphone with dual sim - includes preloaded data and two sim cards to ensure patient can roam across multiple networks if connection is unstable.

All monitoring devices integrate to the Biofourmis mobile app available on any smartphone.

Conditions eligible for treatment:

- Pneumonia
- Chronic obstructive pulmonary disease
- Cellulitis
- Urinary tract infection
- Stable heart failure
- Asthma
- Diabetes
- Deep Vein Thrombosis

Qualifying patients

The Treating physician will determine patient eligibility and suitability for the programme.
The final recommendation is the responsibility of the members treating doctor post a comprehensive risk assessment with the member.

Eligibility criteria

- Adult member (18 years or older)
- Need hospital-level care that can be given in a general ward
- Live within 30kms of a hospital with an emergency room (casualty unit)
- Live in Cape Town, Durban, Pietermaritzburg, Johannesburg or Pretoria
- Have enough family support to be safe at home
- Have running water within the home
- Have electricity within the home
- Subject to exclusion list and condition specific criteria

Technical Details

At the time of pre-authorization, the treating doctor will be able to choose which network facility their patient will be admitted to.
The following home-based providers are included on the network:

- Discovery Hospital at Home
- Mediclinic at Home
- Quro Medical

All services offered within Home-based Hospital Network fund from member's Hospital Benefit where there is a valid pre-authorization in lieu of hospitalization.

Keycare Updates

Overview:

The Keycare plan has approximately 460 000 members and continues to offer members affordable access to good, quality healthcare.
There is overwhelming medical evidence supporting the understanding that patients experience improved health outcomes when their primary care is coordinated through a single primary care GP.
Keycare members that visit their Primary GP only have an 8% lower admission rate

Updates in 2024:

In alignment with achieving improved health outcomes, ensuring efficient healthcare referral pathways and improved healthcare coordination, the following benefit changes will be implemented across the KeyCare Series from 1 January 2024:

- **Primary GP nomination:** To align with the Scheme's single care coordination strategy, KeyCare Plus members will no longer have cover for secondary GP consultations, with all day-to-day healthcare needs being addressed and coordinated by one nominated primary GP.
- **Out of network consultations:** Similarly, out-of-network GP consultations for KeyCare Plus, KeyCare Start and KeyCare Start Regional members will be replaced with one annual consultation with a network nurse or healthcare provider at a network pharmacy clinic.
  Members will be referred for a virtual consultation with a GP or an in-person consultation where needed.
- **Changing a nominated GP:** KeyCare members have the option to change their nominated GP three times per year, after which approval is needed.

Hospital Network Changes
There have been changes made to the KeyCare Hospital Network to maintain the highest quality of care, ensure efficient healthcare delivery and deliver value for members.

Benefit Rules | Updates
To align with the intended product design of the KeyCare series, to provide PMB level of care, the following procedures will be added to KeyCare exclusion list:

- Tonsillectomies
- Myringotomies
- Adenoidectomies

Cover will be provided in emergencies or when PMB treatment is required

Comprehensive Series Updates

Overview
In 2024, Discovery Health will introduce, plan and benefit changes to the Comprehensive Series so that it remains the leading plan as it is the plan of choice , occupying almost 90% market share at this point. This will provide a clear distinction from the Executive Plan.
For 2024 we are proud to announce our Classic Smart Comprehensive Plan.
The Comprehensive plan range will be consolidated into two options, Classic Comprehensive and Classic Smart Comprehensive.

Technical Details | Default strategy:
Members on impacted plans will have a default plan if no choice is made. Members will be able to change their plan until 31st March 2024. If no feedback received, they will default to closest plan.
Communication to inform them of this change and that they have until 31 December 2023 to choose a different plan on Discovery Health Medical Scheme.

Changes | Benefit Updates for 2024
The following changes will be made in 2024:

- **Above Threshold Benefit (ATB) :** Introduction of a limited Above Threshold Benefit (ATB) on the remaining Comprehensive plans (97% of policies unaffected by this)
- **Medical Savings Account (MSA):** Introduction of a Medical Savings Account (MSA at 15% of the total contribution) portion to the Classic Smart Comprehensive Plan to enhance the day to day offering
- **GP Consults:** Unlimited GP consultations at a GP in the Smart network with a R65 co-payment. The Medical Savings Account can be used to fund this co-payment
- **Child dependant risk contribution:** Child risk contribution rate reduced by 17.9% compared to 2023.
- **Oncology Innovation Benefit:** Change the Oncology Innovation Benefit rate of cover from 75% to 50% (99.5% of policies will remain unaffected)
  - We are also Increasing the copayment on a defined drug list on the Oncology Innovation Benefit
  - Members accessing one of the drugs on the defined list in their current approved treatment plan will be grandfathered. The new funding rule for these drugs only apply for new treatment plans.

Thank you for your ongoing care of patients on Discovery Health Medical Scheme.

Medscheme CORNER

Q (Dr ********* Incorporated Practice Number: 012345):
Wants to know:

- They received a POLMED letter (on 31/01/24) about upgrading to REPI1 as from 01/01/24 – 31/03/24?! (period Jan to end Mar 24)
- Currently they are of course still demanding the REPI 2 amount (see attached statement)
- If the PERIOD they will be on REPI 1 = 1/01/24 - 31/03/24, why would they only get their letter on 31/01/24?

(It was reported to **********)

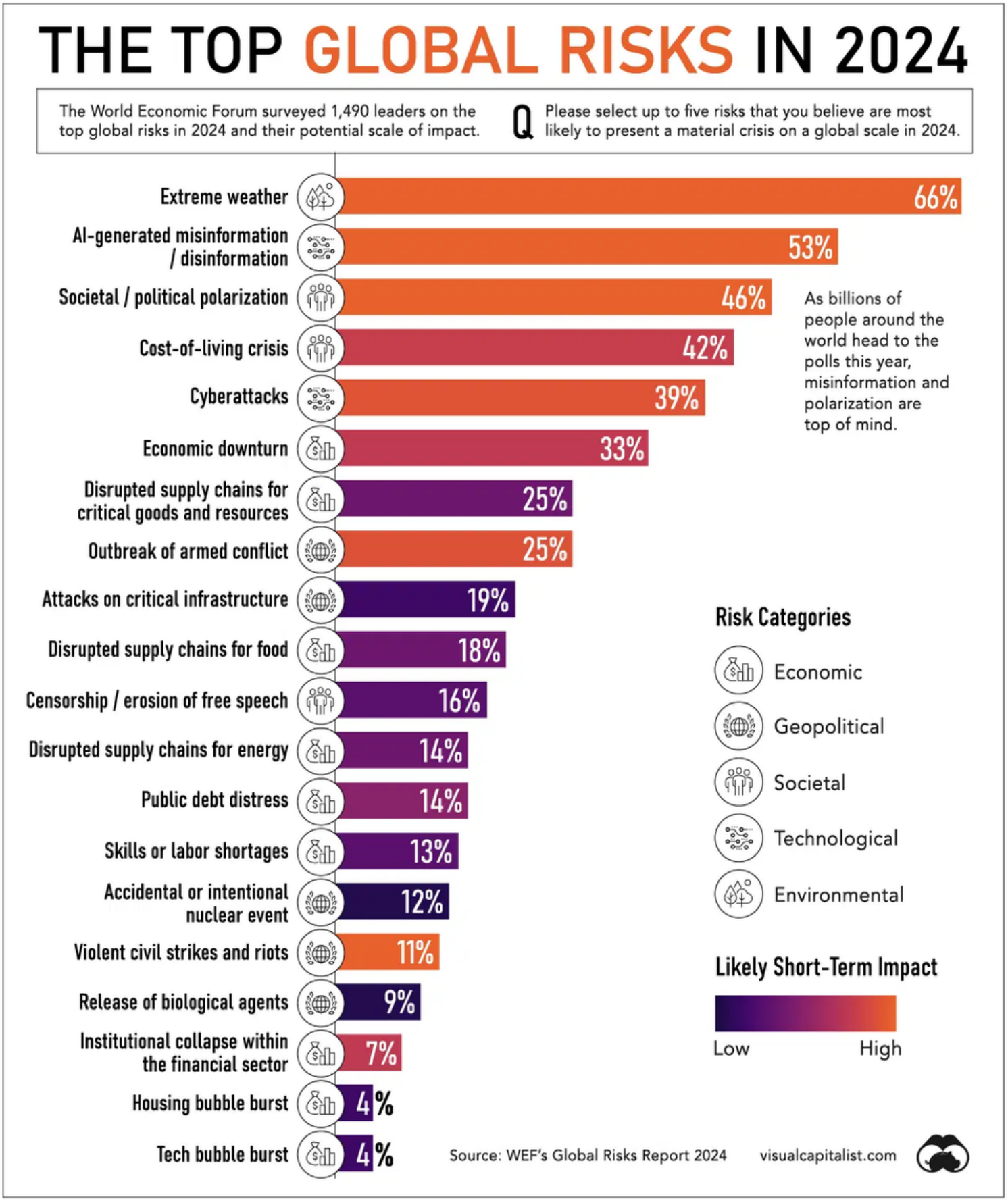
A ***********: Medscheme Advanced Specialist: Health Professions Strategy
'I am taking this up with our actuarial and operations team in charge of sending out the profiles timeously, as well as with scheme.
Will revert on outcome in due course'

2024 'High-Quality Integrated Chronic Care FP - Network Medscheme ICC FP Network Agreement' (Only for Bonitas, Fedhealth & AECI)

ICC Prolonged Consultation 07347 1 R965.00

Currently tariff code 07347 is rejecting incorrectly: Medscheme's IT Department is investigating the issue.

Once resolved all affected claims will be reprocessed.



Qualicare Electronic Doctor Network.

Free electronic listing (valued at R6,000.00 per year) of your practice, geographic location, special areas of interest and pictures of your practice can be featured on our Electronic Doctor Network which is only available to CPC/Qualicare Members and Shareholders!!

Our highly successful electronic doctors network see www.qualicaredoctors.co.za has rapidly expanded across the Western Cape Province, and to date has approximately 200 doctors.

As a Member or Shareholder you are still entitled, **at NO charge**, to list your practice on the "EDN" showing your name, practice name, GPS coordinates, areas of special interests, and any specific features which you would like to bring to the attention to prospective patients then please complete and return the form below at your earliest convenience should you be interested to join the growing network.

This is a limited offer open only to Shareholders and Members which is worth over R6,000.00 per year and is brought to you as a member or shareholder benefit at no charge.

Practitioners Details * Compulsory to complete – for a successful listing.

*First Name: _____

*Surname: _____

*Professional Degrees e.g. M.B.ChB._____

_____

Professional Body Memberships: _____

_____

*HPCSA Number: _____

*Board of HealthCare Funders PCNS Number: _____

DOH Disp Lic Number (if applicable): _____

Areas of Special Interest and Focus: e.g. Paediatrics, Bariatrics, Occupational Health: _____

_____

Contact Details

*Contact Number: (Practice)_____

*Email Address: _____

*Alternative Number: _____

Fax number: _____

Practice Details

*Practice Name: _____

Group PCNS: _____

*Practice Address: _____

_____

GPS Location: _____

Qualicare EDN ..... continue to page 63

Please also provide:

1. **Photo of yourself** - So that the patient can familiarize themselves with the Dr they are going to see.

2. **Photo of the outside of the Practice** – So the patient will recognize the correct building and know what to look out for when coming to visit the practice.

3. **A short bio – interests, hobbies & education** – This gives the patient some trust as they will feel they know you and will feel at home.

Please feel free to contact Annerè van Pletsen CPC/Qualicare Consultant at annere@cpcqualicare.co.za

I permit CPC/Qualicare to list my name, surname, the name of my practice, my practice details, and further details provided by me in this application, and my GPS Coordinates on the *"Electronic CPC/Qualicare Doctor Network"* at no cost to me or my practice (tick the appropriate block).

Yes I do agree to the above, in terms of POPIA Act 4 of 2013

☐

Click on the link to complete the form:
https://www.qualicaredoctors.co.za/new-form/

01 Feb 2023 - 29 Feb 2023

www.docweb.co.za

docweb traffic

Reported period	Month Feb 2024				
First visit	01 Feb 2024 - 00:32				
Last visit	29 Feb 2024 - 23:40				
	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Viewed traffic *	**1,153**	**1,525** (1.32 visits/visitor)	**3,889** (2.55 Pages/Visit)	**23,476** (15.39 Hits/Visit)	**4.02 GB** (2760.69 KB/Visit)
Not viewed traffic *			**22,144**	**34,881**	**6.60 GB**

* Not viewed traffic includes traffic generated by robots, worms, or replies with special HTTP status codes.

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Facebook page overview

Last 28 days

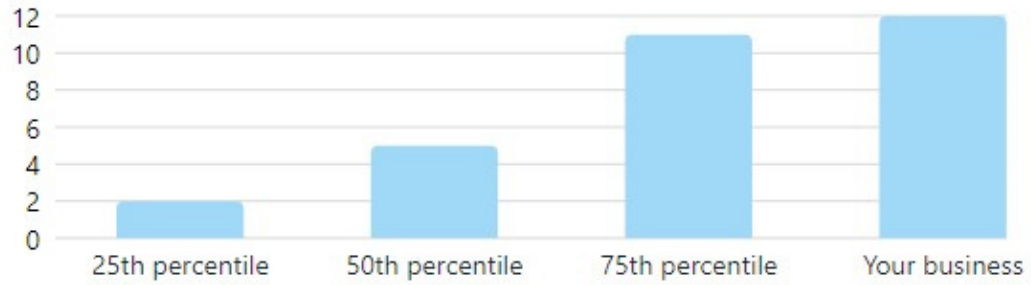
Post reach
84

Post engagement
84

Published content

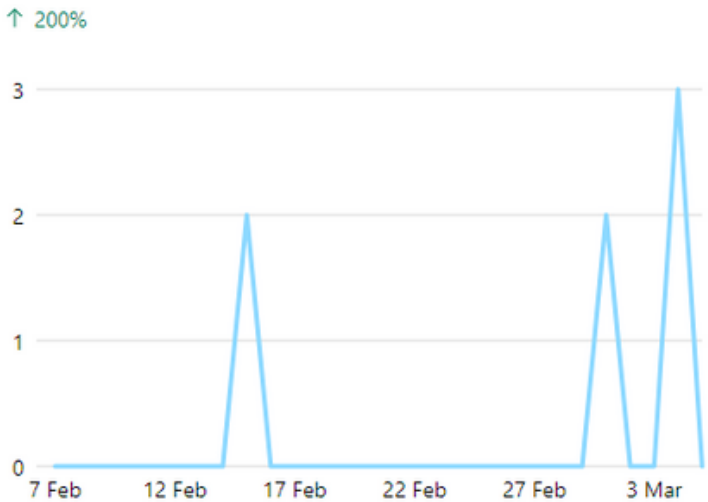
Higher than others

How often your business published versus others in this category



Instagram reach

↑ 200%



Disclaimer:

The entire contents of the CPC/Qualicare Newsletter is based upon the latest and most up to date information at the time of sending.

Due to the fluency of the situation, information changes daily. Please visit our website for more updated information.

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