



said that 'the termination of the contract is part of an overall process of service strengthening and reconfiguration. The initial agreement clearly stipulated that the contract could be terminated with one month's notice to either party'.

Maja said that Bara had an average 75% bed occupancy in the medical wards (the norm for bed occupancy is 80%), which indicates that there are beds that could be used. The MEC was also concerned that the initial agreement with LifeCare was not subject to an open tender process. The 24-hour service was established to relieve the pressure on admissions at Bara of patients who could be managed at district and regional hospitals. It took patients with acute illnesses, including HIV/AIDS, TB, pneumonia, epilepsy and diabetes.

However LifeCare MD, Dr Trevor Frankish, expressed disappointment at the decision not to renew the contract, because they believed that they provided a quality and cost-effective service that reduced overcrowding at Baragwanath.

### NEW GETMED ACCESS CARD

GPNet recently introduced an access card called 'GetMed' in conjunction with Anglo Gold's Igolide Healthcare Access, and it is already being used by 2 300 patients. The system is the first of its kind to be endorsed by a doctor grouping.

Patients use the access card for acute medication and for visits to GPs, specialists, radiologists, pathologists, dentists and optometrists in a managed care environment targeting the lower income market.

Dr Johan van Zyl, GPNet Group Executive, said that the system has been piloted successfully in Carltonville, Welkom and Klerksdorp since January 2002. GetMed is a pay-as-you-need-system that is free of cross-subsidisation. It is based on a cost-per-encounter principle which enables patients to budget upfront for health care expenditure.

### RESOLUTION LAUNCHES DEBIT CARD

Resolution Health recently introduced a health debit card which can be presented at any health care provider to verify electronically whether sufficient funds are available before authorising payment.

Bennie de Beer, MD of Resolution Health Ltd, said that the holder of the Visa-based card and the Mercantile administrator would decide how much money should be deposited into a personal savings account every month. It can only be presented at medical service providers and pharmacies, which then removes the patient's need to submit claims to the medical aid.

At the end of every year the member can withdraw the saved amount and if the holder belongs to the scheme's hospital plan, in-hospital expenses cover all major catastrophes.

### TELEMED ON PRICE LIST SYSTEM

Telemed medical aid scheme, which serves 25 000 Telkom staff, recently awarded its pharmaceutical benefit management contract to Interpharm, a Medscheme subsidiary.

For the scheme's 60 000 members, the deal promises the speedy processing of their medicine claims and management of dispensing through Medscheme's controversial Medicine Price List system.

Luke Harwood, MD of Interpharm, said that they plan to introduce online scripting for medical practitioners. This will enable the prescribing doctor to have all the relevant financial and clinical rules of Telemed on screen. The script could then be sent directly to the pharmacy or the patient could leave with a signed printout.

Interpharm processes about 1.2 million claims every month - 96% of them in realtime - and has around 42% of market share.

### LEGISLATION

### SUMMARISED AMENDMENTS TO THE REGULATIONS MEDICAL SCHEMES ACT: PART 1

*By Elsabé Klinck*

The amending regulations to the Medical Schemes Act of 1998 (as amended) were published on 4 November 2002 in the Government Gazette. The regulations will come into force on 1 January 2003. Various aspects dealing with prescribed minimum benefits will unfortunately only come into operation on 1 January 2004. All persons or groups entering into managed care agreements from 1 January 2004 will have to be accredited by the Council for Medical Schemes.

SAMA is, in general, extremely satisfied with the way in which many of its submissions were incorporated. Doctors should be vigilant and ensure that schemes adhere to the regulations, especially regarding accounts, managed care agreements, protocols and formularies.

Under the various headings below, an indication is given where the regulations have been left unchanged, as well as where changes were effected by the Nov 2002 regulations or regulations that are totally new.

#### Definitions (changed)

Most of the definitions in regulation 1 have been scrapped, with only those pertaining to 'child dependent', 'practice code number' and 'the Act' remaining. Many of the relevant definitions are now next to the related regulations.



**Regulation 2: Administrative requirements (unchanged)**

Regulations applicable to the registration of medical schemes.

**Regulation 3: Membership (unchanged)**

Requires of scheme to provide member with proof of membership and certificate on termination.

**Regulation 4: Administration of a medical scheme (unchanged)**

Set requirements for the rules of a medical scheme. An important subregulation states:

*A medical scheme that provides more than one benefit option may not in its rules or otherwise, preclude any member from choosing, or deny any member the right to participate in, any benefit option offered by the medical scheme, provided that a member or a dependant shall have the right to participate in only one benefit option at a time.*

This means that the scheme may not compel a member on, for example, health grounds, to move from one option to another.

**Regulation 5: Accounts by suppliers (unchanged)**

Sets the requirements for doctors' accounts or statements.

**Regulation 6: Manner of payment of benefits**

Currently, if a scheme thinks that an account, statement or claim is erroneous or unacceptable, it must inform the member within 30 days, who must then resubmit a corrected account within four months. This means that doctors should inform their patients of any returned or non-paid accounts.

From 1 January 2003 the scheme has to, within 30 days, inform the member and the doctor if it thinks the account is unacceptable and allow 60 days for the provider to correct the account. If the scheme fails to do either of these two things, 'the medical scheme bears the onus of proving that such account, claim or statement is in fact erroneous or unacceptable'.

SAMA thinks that the use of the wording 'proving ... in fact' entails more than mere allegations of inconsistencies in claims, or deviations from claims profiles. The doctor concerned is entitled to the information on which this is 'proven' and to react to/challenge that.

**Regulation 7: Definitions for chapter on contributions and benefits (changed)**

The phrase 'preferred provider' is substituted with the phrase 'designated service provider'. A designated service provider refers to a 'provider or group of providers selected by a medical scheme as the preferred providers to its members for diagnosis, treatment and care in respect of one or more of the prescribed minimum benefit (PMB) conditions'. This means that designated service providers would only be preferred for PMB conditions. The HPCSA has in the past ruled that the

invitation to become a designated provider should be open up to all practitioners in an area. Those willing to comply with the criteria should be permitted to act as designated providers.

The second definition is that of 'emergency medical condition'. It is defined as 'a sudden and unexpected health condition requiring immediate medical or surgical treatment, where failure would result in serious impairment or dysfunction or would place the person's life in serious jeopardy.

'PMB condition' is defined as a condition contemplated in the Diagnosis and Treatment Pairs or any emergency condition.

**Regulation 8: PMBs, co-payments, designated providers and formularies (changed *in toto*, but enforced on 1 January 2004)**

Medical schemes have to pay in full and without co-payments for the diagnosis, treatment and care costs of PMB conditions. For a designated service provider, this means that s/he would not be permitted to charge more than the benefit offered.

A scheme may in its rules provide for these services to be paid in full only if the services are obtained from a designated service provider. A co-payment or deductible (to be determined in the rules of the scheme) may be imposed on the member for seeking the services from a non-designated provider. This rule does not apply where the service was obtained by the member involuntarily:

- where there is, for example, no designated provider available without unreasonable delay or
- where immediate medical or surgical treatment was required which reasonably precluded a beneficiary from obtaining such treatment from a designated provider or
- there was no designated provider within reasonable proximity of the business or residence of the member.

The above should not be construed to prevent a scheme from employing appropriate interventions to improve efficiency and effectiveness, including pre-authorisation, treatment protocols and formularies. Efficiency and effectiveness should not be read to mean only financial considerations, but also the long-term health care management of patients.

Where a formulary includes a drug that is clinically appropriate and effective for a PMB, and the patient knowingly declines that drug, the scheme may impose a co-payment on the member. This subregulation means:

- that a doctor could (and indeed should) inform his/her patients of more effective alternative drugs;
- that a doctor can dispute the clinical appropriateness or effectiveness of a PMB drug on a formulary;
- the scheme would be imposing a co-payment where the patient knowingly declines the prescription of such a formulary drug.



A scheme may not prohibit the initiation of appropriate interventions prior to receiving authorisation for an emergency medical condition.

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## INFORMATION TECHNOLOGY

### WEBSITE REVIEW: AFROAIDSINFO

According to the UNAIDS Report of November 2002, 27.5% of people in Southern Africa are HIV-positive – this translates to 9.5 million people. It is imperative to bring accurate, valid and credible information to the population to curb the pandemic. To this end, the Medical Research Council (MRC) launched their new HIV/AIDS portal, AfroAIDSinfo, at a function at the MRC Convention Centre in Cape Town recently.

AfroAIDSinfo is an Internet project of the South African Medical Research Council. The aim of the project is to disseminate important information on HIV/AIDS to researchers, the health profession, the public, infected individuals, educators and policy-makers.



*Dr Ebrahim Rasool, Minister of Finance and Economic Development in the Western Cape Government*

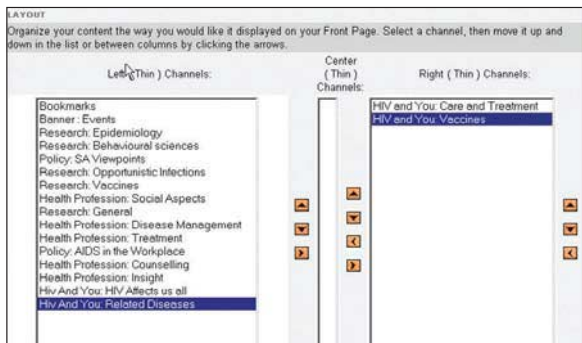
In declaring the portal open, Ebrahim Rasool, Western Cape Minister for Finance and Economic Development, said that good scientific information is the most important weapon in the fight against AIDS. Furthermore, he said that it is everyone's job to manage HIV/AIDS – it cannot be 'pigeonholed' into the health portfolio alone. AfroAIDSinfo has been formally endorsed by the Ministries of Health in both Botswana and South Africa.

The portal has been designed with a tremendous amount of thought and planning, and while it is not the prettiest website around, it sure is packed with information.

After spending time perusing the various sections dealing with the clinical and epidemiological and other issues concerning HIV/AIDS, one can go to the 'Gateway Links' which supplies a fairly good list of the major HIV/AIDS sites. I hope that the webmasters will add 'Red Ribbon', 'HIV InSite



Schoolchildren learn to navigate their way around the MRC portal.



Knowledge Base', 'The Body' and 'Secure the Future' to their list.

The 'Press Room' link on the site relays users to documents which deal with the role and content of the media in regard to HIV/AIDS. Much of the content is prepared by the Centre for AIDS Development, Research and Education (CADRE), in Johannesburg.

Finally, the major factor that makes the site attractive to users is its fast speed. There are no fussy graphics, and while it has its own character and branding, this is done in an unobtrusive way that allows rapid retrieval of information.

Elmarie van Wyk, Hendra van Zyl and Gillian Staniland, who designed and constructed the site, are to be congratulated. This portal is worth many visits and many returns. It's great!

**Fred N Sanders**