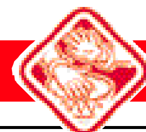

would enable construction of the trauma unit to begin immediately. She said that the new unit, to be called the Discovery Health Trauma Unit in Partnership with the Anglo American Chairman's Fund, is expected to be completed by April 2004. Professor Heinz Rode said that the unit would expand the hospital's ability to research childhood injuries.

RESOLUTION'S REALITY PROGRAMME ARRIVES

In line with the aim to become one of the major players in the health care funding industry, Resolution Health Medical Scheme is announcing yet another value adding product: Reality, an innovative health and lifestyle programme, enables members to regard health and illness in a totally different way, says Jannie Kotzé, chairman of Resolution Health.

'Consumers are increasingly moving away from the traditional way of looking at a cure for illness and are focusing more on wellness and prevention. Medical schemes implement programmes to reward members for healthier lifestyles and encourage them to take responsibility for their own health.'

The Reality programme is aimed at providing guidance and advice to members on how to manage their health care themselves. Reality is a wellness programme for a new generation. It has been designed so that every member of Resolution Health has immediate access to health-related benefits and information at no extra cost. Reality Plus is the portion of the programme where the member upgrades his membership by paying a nominal fee for health information, tools and rewards. Reality Plus rewards people for positive lifestyle changes, maintaining a healthy lifestyle and for regular health checks.

Reality also gives members access to special discounts and rewards through 'Health Partners' such as the Health Connection Gym, Weight Watchers, Body for Life and Computicket.

'With the launch of the Reality programme, Resolution Health is providing its members with the means to take personal responsibility for their health and well-being. Reality will also enable members to keep their medical expenses in check by providing an alternative way to look at health care,' says Kotzé.

MANAGED CARE

In this section:

- credentialing liability
- malpractice liability
- utilisation review liability.

From a medicolegal point of view there is very little by way of a legal precedent with regard to the legal questions that arise within the various relationships in a managed care environment. Liability has proved to be important in especially three areas in the United States managed health care environment, namely credentialing, malpractice and utilisation review.

CREDENTIALING LIABILITY

Credentialing refers to the process of selection of providers according to certain predetermined criteria to participate in a network of providers of a particular funder. Clinical competence, training and experience of practitioners who seek to provide care in the managed care setting are reviewed. It provides a means of quality control through the application of minimum standards to participate in a provider panel. Specific criteria and pre-requisites are applied in determining initial and ongoing participation in a health plan. Should an incompetent provider for instance be selected and included in a directory of providers to be circulated among patients, a funder could expose itself to legal action in the event of a patient being harmed because of the provider's incompetence. Credentialing criteria need to be carefully set with the participation of providers.

Where providers are employed by the managed care organisation, vicarious liability could arise for the organisation should the provider prove to be incompetent and the patients suffer harm.

MALPRACTICE LIABILITY

Liability in the case of malpractice affects mainly providers of care. Cases of malpractice are generally covered by the individual practitioner's professional indemnity cover. Should a relationship of employer-employee exist between a funder and a provider, the funder could be exposed to legal action on a basis of vicarious liability.

UTILISATION REVIEW LIABILITY

Liability in relation to utilisation review, refers to the situation where care is denied or disrupted by a funder and the patient suffers harm as a result thereof. Mechanisms used to determine the appropriateness of care are clinical guidelines. Should a practitioner recommend certain treatment, a test or a procedure that is not indicated in terms of a specific guideline, the funder concerned may rule that benefits will not be provided should that treatment, test or procedure be performed. A patient is not prohibited from undergoing that treatment, test or procedure but is required to fund it him/herself. If the funder would deny benefits for reasons other than funding, it would certainly be exposed to legal action.

It could be argued that the denial of funding could effectively be a denial of care depending on a patient's financial position. The courts will have to rule on liability in these instances. During a utilisation review process an incorrect conclusion about medical necessity could result in the wrongful withholding of necessary care, or the disruption of the continuity of care, which could seriously harm a patient. The medical practitioner should assist the patient in trying to convince the funder concerned that the proposed care is medically necessary and should be funded by the funder. Should funding still be denied, the medical practitioner should inform the patient of his/her recommendation and the funder's decision. The patient could still select to undergo the recommended care. Should the patient not be able to fund the care and it appears retrospectively that the care was medically necessary and the patient suffered harm, the funder might still be at risk. The medical practitioner is under a legal obligation to treat his/her patients with reasonable skill and care.

Case study

In the USA, this form of liability has been the subject of numerous court cases. In the landmark case of Wickline v. The State of California (1986) the court laid down certain principles in the case of prospective utilisation review. In this case a woman's leg was amputated following complications after her discharge from hospital following surgery. The treating surgeon suggested longer inpatient stay than what was approved by the funder. The funder was sued on the basis of determining alleged premature discharge from hospital, which resulted in the patient losing her leg.

The principles laid down by the court are the following:

- the medical practitioner stays ultimately responsible for the care of the patient (in this case for the discharge of the patient from hospital)
- should a funder deny funding for recommended care, the medical practitioner should act as a patient advocate and attempt to convince the funder to fund the proposed care
- should medically inappropriate decisions be made by a funder as a result of defects in the design or implementation of cost-containment mechanisms, the funder could be held liable.

In other words, managed care organisations may be held liable for withholding services as a result of defective utilisation review policies or if they incentivise providers to withhold necessary care.

The court concluded by saying, 'While we recognise, realistically, that cost consciousness has becomes a permanent feature of the health care system, it is essential that cost limitation programmes not be permitted to corrupt medical judgement'.

The Wickline case has also been followed in an appeal court decision, Wilson v. Blue Cross of Southern California (1990). The principles laid down in the Wickline case could be used as guidelines that are likely to be followed by our own courts.

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