NEWS

THE INEVITABILITY OF ANTIRETROVIRALS

We are well aware of the 'skirmishing' surrounding the provision of antiretroviral (ARV) drugs to HIV / AIDS patients in our hospitals. Postponement of meetings, delays in cabinet seeing the report of the task team evaluating the cost implications of using ARVs and looking at infrastructural and sustainability issues, statements by the Minister of Health and the Deputy President Jacob Zuma and the TAC, have fuelled a constant stream of media reports. And still, as of the end of June, no finality has been reached despite promises from government.

Virginia van der Vliet, who has written widely on the South African AIDS epidemic assessed the situation in PulseTrack of 24 June:

'After a meeting between the SANational Aids Council (SANAC) and the TAC, deputy president Jacob Zuma, SANAC chairperson, said: "Regarding the introduction of antiretrovirals in the public sector, it was noted that government is at an advanced stage of dealing with the Task Team Report on the Expanded Response to HIV / AIDS, with a view to making a decision as soon as possible."' He was not, however, prepared to give any dates. The TAC's Zackie Achmat said he saw the meeting as 'a breaking of the log-jam, and we hope the government will act very urgently'. He added: 'We really are giving the government its last opportunity.'

The authors of the South African Health Review 2002 (www.hst.za / sahr / 2002) released in March this year believe that universal access to such treatment will be an inevitable reality within the next 3 - 7 years. They warn that lack of capacity and operational weakness currently could undermine the health system's ability to deliver basic care. ARVs must not be allowed to 'steal' resources from existing health interventions. Rather ARV programmes should serve as a catalyst to improve all health services especially in rural and remote areas.

Dr Kgosi Letlape, chairman of the SAMedical Association believes capacity exists to treat about 100 000 patients needing ARVs within 3 - 4 months. Although the task team report might ensure that finances for ARVs become available, he doubts whether there is the political will to follow through. 'We as South Africans still participate in a kind of genocide against ourselves. We are the only nation with a policy of no treatment.' Perhaps Letlape is about to be proved wrong, says Van der Vliet.

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CURAMED GROUP OF SPECIALISED HOSPITALS

Clinic dedicated to care of 'diabetic feet' opened

The first private-sector multidisciplinary Diabetic Foot and Ulcer Clinic, catering for the care of 'diabetic feet' opened on the 19 June 2003 at the new Curamed Kloof Hospital in Erasmuskloof, Pretoria. The clinic will be run by the only female registered vascular surgeon in South Africa, Dr Lynne Tudhope.

Dr Tudhope has a special interest in diabetic feet, partly because South Africa has the largest diabetic population in the world, relative to our population size. She has recently returned from the International Diabetic Foot Congress in Noordwijk, Holland (held every 4 years). The clinic will offer the services of orthopaedic surgeons, a vascular surgeon, specialist physician, radiologist, podiatrist, wound care sister and orthotist.

Worldwide, 250 million people will suffer from diabetes by 2010. Internationally, amputation as a result of diabetes is at about 15% of all patients. However, it is calculated that the South African amputation rate due to this cause is as high as 90%.

Companies involved in assisting the clinic to get started are Smith & Nephew / Dermagraft Division, Tyco Healthcare, Novo Nordisk and Aventis.

MEDICAL AIDS DETERMINED TO STAMP OUT FRAUD

Medshield Medical Scheme has reiterated that it will continue to stamp out corruption in the medical industry in its zero tolerance approach to medical fraud.

In a recent case, Dr MASihlobo, a homeopath, allegedly defrauded Medshield of R800 000 over a period of 2 years. Sihlobo was arrested after an extensive investigation into his alleged misconduct by Medscheme Special Investigations Department, and a search of his premises in September 2000 by members of the SAPS and investigators from Strategic Solutions.

The search of his premises revealed a large quantity of scheduled medicine, up to and including schedule 5 substances, which homeopaths are not permitted to possess in terms of the Medicines Control Act.

The legality of the search of Sihlobo's premises has been challenged. It has since been ruled that the fact that the SAPS was assisted by specialists from Medscheme did not make the search unlawful and that it was conducted properly within the parameters of the relevant sections of the Criminal Procedures Act.

The Medscheme Special Investigations Department has recovered over R35 million in fraudulent accounts from medical practitioners and worked with Interpol to expose 18 homeopaths, including Sihlobo, who were practising in the country with fraudulent qualifications.

Some other recent cases include:

- Anurse who had managed to obtain a practice number and was practising as a psychologist.
- R400 000 being re-paid to medical schemes after a dentist who had been claiming for crowns, fillings and bridgework had been found placing gold inlays into patients' teeth instead.
- Practitioners claiming for services rendered to non-registered individuals.

PRICE REDUCTION ON GSK ANTIRETROVIRALS FOR SA HIV CLINICIANS SOCIETY MEMBERS

GlaxoSmithKline's (GSK) antiretroviral (ARV) products are soon to be offered to patients of paid-up members of the Southern African HIV Clinicians Society (who practise in South Africa) at not-for-profit prices, through a Global Access Programme.

Details of the programme and the process will be released shortly, but in the interim, doctors wishing to access these preferentially priced GSK ARVs are asked to ensure that membership fees are up to date and that a Society membership number has been issued. This number will have to be quoted on Access Programme patients' scripts. To obtain a membership number, e-mail patsolan@global.co.za or fax the Database Manager, Mr Patrick Solan, at (012) 669 0935.

If you wish to join the SAHIV Clinicians Society, fees may be paid directly into the Society's bank account:

Account name: SAHIV Clinicians Society

Nedbank Account Number: 1581 048 033

Branch Number: 158 105

Branch: Campus Square, Melville, Johannesburg.

The annual membership fee for doctors in the private sector is R250. The annual membership fee for doctors in the public sector is R125. Please write your name and initials legibly on the deposit slip / proof of payment and fax to:(012) 669 0935 or (011) 453 5059 marked: The Accounts Department, SAHIV Clinicians Society.

For more information about the SAHIV Clinicians Society, contact Penny Penhall, Manager SAHIV Clinicians Society, Suite 233, PostNet Killarney, or Private Bag X2600 Houghton 2041. Tel (011) 453-5066, fax (011) 453-5059, cell 083 602 6636.

IMPACT OF HIV ON CHILDREN – UCT REPORT

Areport published by the University of Cape Town's Centre for Actuarial Research estimates that about 6.5 million South Africans are HIV-positive, including 3.2 million women of childbearing age (between the ages of 15 and 49).

It describes the pandemic as one of the greatest threats to the realisation of child rights in South Africa and in sub-Saharan Africa. 'The illness and death of adults as a result of HIV / AIDS has a profound impact on the survival, development and protection of children in South Africa.'

It finds that four times as many women aged 15 - 24 are affected than men. About 75 % of HIV-infected people in South Africa are in stages 1 and 2 of the disease's progression, and therefore they have not yet developed symptoms and many do not know their status.

Between January and December last year 89 000 children were infected with the virus as a result of being born to an HIV-positive mother. This figure is around 7.5 % of the total number of babies born during this period.

Last year alone, about 150 000 children lost a mother to AIDS.

The institute said that without any major new health interventions, close to 2 million children would lose a mother by 2010, and this would mainly be due to AIDS.

The provision of antiretrovirals in the public sector was a crucial step towards decreasing the number of children who would be made vulnerable as a result of HIV / AIDS. - PulseTrack

TAKING THE PAIN OUT OF GOING TO HOSPITAL

Managing the hospital benefits of medical aid schemes – from pre-authorisation to the processing of claims – has always presented a challenge for health care funders and administrators, particularly in the South African medical schemes environment. Medscheme has developed a fully integrated system to manage the hospital benefits for a number of the medical schemes it administers. According to Medscheme CEO, Andre Meyer, the system has been tried and tested with positive results in a number of medical schemes.

The system consists of six integrated components, namely pre-authorisation, integration module, claims management, middleware, correspondence and a data store. The pre-authorisation component makes available to the pre-authorisation agent all the financial and clinical information relevant to a member or beneficiary, including benefits, waiting periods, chronic medicines and previous events such as operations and illnesses.

As soon as a pre-authorisation request is received, the pre-authorisation nurse or agent can confirm the membership status of a beneficiary, verify his or her benefits and screen any major medical events and disease profiles. This means that when a member is admitted to hospital, all their relevant details are available immediately and there is no need to contact the medical scheme directly to establish the membership status or disease history.

The pre-authorisation process will determine the level of care (accommodation), the initial length of stay approved for funding and the criteria for evaluating the clinical appropriateness of admission.

An on-line referral mechanism tracks the case and whenever the scope of the initial authorised event changes, for instance if the patient returns to theatre or the approved length of stay is exceeded, the member, medical practitioner and facility are notified of the change in the scope of the initial authorisation.

The claims management component allows for the electronic receipt of hospital claims and makes allowance for different pricing agreements with hospital groups, based on the conditions of the medical scheme. It also has the ability to audit claims against the scheme's clinical rules and protocols so that claims and authorisations can be matched electronically.

Communication between members, schemes and hospitals is greatly enhanced with the correspondence component, which can generate faxes, e-mails and letters from the system.

CAMPAIGN TO END POLIO BY 2005

South Africa's Health Department has given itself a deadline of 31 December 2005 to reach a national polio-free status. Launching the National Polio Countdown, Health Minister Manto Tshabalala-Msimang called on parents and caregivers in the country to take their children to health care centres for oral polio vaccination. Minister Tshabalala-Msimang said the country could not afford to have children crippled or killed by polio when there was an effective and safe vaccine to use.

Among those children paralysed, 5 - 10 % die when their breathing muscles become immobilised. There is no cure for polio but it can be prevented with a vaccine.

'We encourage parents, caregivers and communities to continue supporting the immunisation programme. Immunisation is a critical ingredient of every child's survival and good health,' Dr Tshabalala-Msimang said. 'Achild that is not immunised is at risk of suffering from polio and is also a danger to other children. No child should be deprived of the immunisation as this has serious implications for both the child and the community,' she added.

Dr Tshabalala-Msimang emphasised that polio eradication was also a global effort, which required all countries to combine their efforts to reach the goal. The polio eradication coalition includes governments of countries affected by the disease, private foundations, development banks and donor governments.

'This initiative requires commitment from the public and private health sector, the society and other sectors of our society. Our goal is to rid the world of polio once and for all,' said the Minister.

GAUTENG HEALTH CALLS FOR RETRIEVAL OF UNUSED MEDICINES AND DRUGS

Gauteng Health MEC Gwen Ramokgopa has urged communities, support groups and community health workers to help retrieve medicines from patients who no longer needed them. MEC Ramokgopa said the medicines and related drugs should be returned to nearby clinics to be destroyed. She said expired medicines or other drugs in broken or damaged packages and those declared unusable because of mechanical problems encountered such as power failure at cold storages at health institutions, should all be retrieved.

The department's spokesperson Simon Zwane said expired medicines and drugs that were no longer in use by patients for whom they were prescribed, had to be returned to clinics to be destroyed. Mr Zwane continued, 'This is done as a safety measure to ensure that medicines are not used by people for whom they were not prescribed or are not accidentally ingested by children.'

Last year, said Mr Zwane, the department retrieved R1.942 million worth of medicines mostly returned from patients who no longer needed them due to the change in their conditions. He said however that the value of condemned medication had not shown a remarkable increase since 1999. He said drugs and medicines worth close to R2m had been recollected and destroyed annually since 1999. Mr Zwane added that each year, the health department and private pharmacies engaged in a campaign to educate the public about the importance of using medicine properly. The campaign also involved retrieving all medicines that were no longer in use and those that had expired, to be destroyed.- BuaNews

THE TRADITIONAL HEALTH PRACTITIONERS BILL, 2002

The Traditional Health Practitioners Act, 2002 will come into operation on a date to be fixed by the State President by proclamation in the *Gazette*. Its aim is 'To provide for the establishment of the Interim Traditional Health Practitioners Council of the Republic of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for control over the registration, training and practice of traditional health

practitioners and to provide for matters incidental thereto.'

The Act defines traditional health practice and the various activities and practitioners within the field such as a traditional birth attendant and traditional surgeon.

The Act enables the establishment of the Interim Traditional Health Practitioners Council of South Africa and makes provision for control of the registration, training and practices of traditional health practitioners in the Republic of South Africa. It will in addition, serve and protect the interests of members of the public who use the services of traditional health practitioners.

The council will consist of a maximum of 25 members appointed by the Minister, of whom one will be a registered traditional health practitioner and will be appointed as chairperson by the Minister; one will be the vice-chairperson elected by the members; nine will be traditional health practitioners from each province, each of whom will have been in practice for not less than 5 years; one will be an employee of the Department of Health; one will be a person knowledgeable in law; one will be a medical practitioner who is a member of the Health Professions Council of South Africa; one will be a pharmacist who is a member of the South African Pharmacy Council; three will be community representatives; and one will be a representative from a category of traditional health practitioner specified in the Act.

The council will elect an executive committee consisting of not more than eight members, being the chairperson, the vice-chairperson, and six other members. The council may also establish other committees including disciplinary committees, as necessary.

The council will have similar powers to other professional councils in terms of registration criteria, disciplinary action and investigation, and removal of offenders from the register. - PulseTrack

MEDICAL ORGANISATIONS

The South African medical business comprises a myriad of organisations, each with specific roles designed to streamline and regulate an industry fraught with danger in terms of malpractice and fraud.

As a medical aid administrator, what recourse do you have if you have a complaint? As a medical practitioner, who do you turn to if you have a problem? What avenues are open to members of the public if they have queries or concerns about something relating to the industry? How are prices of medications decided? There are literally hundreds of questions of this nature and finding the organisation able to provide an answer is not always easy.

Considering the diverse demographics of South Africa, would a national health system be a feasible option? There are obviously many plusses to such a system – the UK being an example of one that works – but there are many negatives that apply, particularly to Third World countries like South Africa.

Anational system would negate the need for the plethora of organisations playing a role in health care in South Africa. Also, the most obvious positive would be the fact that health care would be free to all. However, because of the huge proportion of disadvantaged people in this country, the carried far outnumber the carriers.

Obviously, the ideal in the industry is an efficient health care system, both in terms of operation and cost effectiveness. That is in an ideal world. The reality in South Africa is another story and it is estimated that fraud and inappropriate behaviour costs the medical industry between R8 billion and R12 billion per annum.

Bearing this in mind, there is a dire need for organisations to police and standardise all elements of health care in this country, from patients, to doctors, to medical aids, as well as pharmaceutical companies. Surely, with so many organisations, there is no reason why the system should not run like a well-oiled machine? You have BHF (Board of Healthcare Funders), HPCSA (Health Professions Council of SA), DFPA (Dispensing Family Practitioners Association), SAMA (SAMedical Association), SADC (SADental Association), CMS (Council of Medical Schemes), MDC (Medical and Dental Council), CPA (Cape Primary Care), to name but a few of the key players in the industry.

We will be highlighting the various players in the medical industry in future issues in an attempt to clarify exactly where they fit in. We welcome comment from anyone involved in the industry, or information about an organisation not listed earlier in this article. Any correspondence can be e-mailed to Guy at gunner@rivalland.co.za.

Rivalland Computing specialises in medical claims administration including price lists, reconciliations and the follow-up of unpaid claims. For further information please contact us on (021) 864-3338.

Guy Hawthorne

MANAGED CARE

ETHICAL ISSUES

Part II of a three-part series to be published in the July, August and September issues of the SAMJ.

Freedom of choice

In general, managed care systems tend to restrict choice. Typically the less freedom of choice in the system, the less expensive the product.