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.

Patients may exercise choice at different levels, namely before enrolment to a particular scheme, after enrolment, or during an episode of illness. Managed care plans usually place restrictions on the member's choice of health care provider, therewith threatening patient autonomy. They could be restricted to panels of practitioners who have agreed to accept a lower reimbursement rate or have demonstrated a history of practising lower cost care. Restrictions can include the selection of primary care doctors, specialists and sometimes may limit the choice of treatment options. In addition, continuity of care may also be disrupted if patients are forced to change doctor for instance to retain their health care benefits. These restrictions can be minimal so that patients can still exercise a choice in selecting a doctor or they can be strict where that patient has little or no choice in selecting a provider.

Denying access to specialist services until approval from a primary care doctor has been obtained can further control behaviour of patients (gatekeeper model). Such a system also controls the referral pattern. Often the primary care doctor or the managed care plan is required to authorise all referrals to specialists and hospitilisation.

Patients also have the right to make informed decisions about the selection of medical schemes that are offered to them. Multiple options are necessary to ensure a patient's freedom of choice as this is an important measure in determining quality of care. This is particularly important in closed systems with no out-of-network benefits. If the employer offers a single option, provision should be made for some out-of-network benefits albeit that a financial penalty is imposed at the time of service (point-of-service).

The ideal health care system maximises opportunity for consumer choice in every area – choice of doctor, health plan and of medical treatment. Giving patients choice ensures competition among providers and funders of care. Choice is fundamental to ensure quality, efficiency and cost-effectiveness in health care.

However, patient autonomy does not guarantee the right to have all treatment choices funded. Some limits on personal freedom are inevitable in a society that tries to provide all of its members with adequate health care. Patient autonomy entails patient responsibility, including a responsibility to abide by societal decisions to conserve health care and to make an individual effort to use resources wisely and lead a healthy lifestyle. Any restriction on choice of provider needs to comply with the policy of the Health Professions Council of SA concerning preferred providers.

Confidentiality

Patients have the right to complete and accurate information concerning their health condition and suggested treatment. Health care providers should continue to promote full disclosure of information to patients enrolled with managed care organisations. The doctor's obligation to disclose treatment alternatives to patients is not altered by any limitations on the coverage provided by the managed care plan. It exists regardless of cost and includes disclosure of potentially beneficial treatments that are not offered under the terms of the managed care plan. Contract clauses that could be applied to prevent doctors from raising or discussing matters relevant to the patient's medical care, should be removed to safeguard the health of the patients ('gag' clauses).

Furthermore, it is important that third parties only receive information with the express consent of the patient or legal substitute. This consent should preferably be in writing. Clearly defined policies and guidelines regarding access, storage and disposal of medical records must be established and adhered to.

Financial incentives

Some managed care organisations rely heavily on financial incentives and disincentives, such as risk-pools, utilisation incentives and administrative barriers to create desired behaviours among their providers. It could be argued that some of these methods encourage advocacy for interests other than that of the patient and that such incentives obscure the doctor's primary duty to the patient.

If doctors are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the doctors' personal financial interests and the needs of their patients. Financial incentives are permissible only if they promote cost-effective delivery of health care and not the withholding of necessary medical care. The most effective way to eliminate inappropriate conflicts is to create the use of financial incentives based on quality rather than quantity of services. It is difficult to judge quality and ideally a system based on outcomes data should be adopted. This examines the quality of care from the patient's perspective across the whole continuum of care. A thorough understanding by the participating doctor of all the incentive systems is also essential.

The following principles should apply:

- incentives to limit care must be disclosed to patients by plans at enrolment and annually thereafter
- limits should be placed on financial incentives that restrict care;calculating financial incentive payments according to the performance of a sizable group of doctors rather than on an individual basis should be encouraged
- financial incentives should be based on quality of care; such incentives should complement financial incentives based on the quantity of services used.

Part III of this series will be published in next month's issue of the *SAMJ*.

Excerpted with permission from the Managed Care section of the Practice Management Programme of the Foundation for Professional Development of SAMA. For information on the FPD courses contact Annaline Maasdorp, tel (012)481-2034;