Billing guidelines from HPCSA needed

To the Editor: I noted with concern an item from the Health Professions Council of South Africa (HPCSA) website, 'Do not be over-charged by your health practitioner' (13 October 2006), by Adv. B Mkhize. After the findings of the Competition Commission, practitioners were left out in the cold as to which fees to charge. As we are all aware, the old Scale of Benefits, now the National Health Reference Price List (NHRPL), has always been a bone of contention. Overwhelmingly promoted by medical insurance companies, it has never been accepted by all doctors. Understandably so, because no other profession has its billing protocols prescribed by an outside, totally unrelated organisation. Furthermore, surely patients should only be informed if 'medical aid rates', i.e. not normal fees as prescribed by our peers, will be charged? More than 80% of anaesthesiologists registered with the South African Society of Anaesthetists charge above NHRPL rates, which the HPCSA deems to be the benchmark. Billing practices cause much confusion and embarrassment for doctors and patients, at times gleefully spurred on by medical insurers. It behoves the HPCSA, in consultation with medical practitioners (not medical aids, not government), to set clear and unequivocal guidelines, or otherwise to remove itself from the field.

P W L Groenveld
1 Castanea Place
Florida Glen
1709
legro@iafrica.com

Controlled trials – thinking the unthinkable?

To the Editor: I read your editorial in the January issue of the *Journal*[1] with pleasure.

In 1996, when the sacred cows of controlled clinical trials were regarded as unassailable, I was Editor of *CME*. At that time I published an article by Dr Bernard Brom entitled 'Controlled clinical trials and anecdotes'[2] in which he did the unthinkable – he suggested that controlled trials were not always the absolute final word on drug or other therapeutic usage. He tried to debunk the mystique of randomised controlled trials, and I expected howls of protest from readers and medical academics – how dared we attack such unassailable institutionalised experience!

To my surprise, we did not receive a single protest either in writing or by telephone. Now your editorial has vindicated my position that the article had value.

Compare a statement by yourself: 'RCTs are by no means always reliable or consistent', with a statement by Dr Brom: 'The controlled clinical trial is dependent on three basic criteria: (*i*) that the two groups being compared are similar; (*ii*) that the individuals in the groups are representative of the population that one is trying to investigate; and (*iii*) if either is suspect, the results could be totally wrong and the methodology should not be classified as strictly scientific.'

The wheel has turned full circle. Thank you, Professor Ncayiyana.

F N Sanders
401 Villa Tiberina
St James Road
Sea Point
fred.sanders@discoverymail.co.za

1. Ncayiyana D. Evidence-based medicine is not all randomised controlled trials and systematic reviews. *S Afr Med J* 2007; 97 (1): 7.
2. Brom B. Controlled clinical trials and anecdotes. *CME* 1996; 14: 1031-1036.

Academic health sectors fail in HIV response

To the Editor: The recent StatsSA analysis[1] of causes of mortality shows that infectious diseases are by some distance the biggest killers in South Africa (Fig. 1). The breakdown of these figures into death per age category showing the dramatic increases in mortality among 20 - 50-year olds, provides a better indication of the devastation that the TB/HIV epidemic has visited on our social fabric (Fig. 2).

One of the key measures of an effective health sector is its responsiveness to the health needs of its people.[2] To what extent have South African academic and tertiary services been responsive to the explosion of the HIV/TB pandemics?

Was the fact that there were no questions asked on HIV/TB in recent Fellowship of the College of Physicians Part I papers exceptional for this exam? If one looks at past paper Is from 2001 to 2006 we see that this is far from exceptional (Fig. 3). As shown in Fig. 4, questions pertaining to HIV/TB comprise 2% of the questions asked over this period. (The questions in all the FCP Part I papers from 2001 to 2006 were analysed in terms of which chapter from *Harrison's Principles of Medicine* would provide the bulk of the answer. All questions on drug management were classified as pharmacology.)

Unfortunately this under-representation of HIV/TB seems to be mirrored in at least some academic institutions. For example one of the tertiary hospitals in the Western Cape has no consultants and no senior or junior registrars covering infectious diseases. While this situation is apparently being given top priority for change, the fact that this unit is in such a

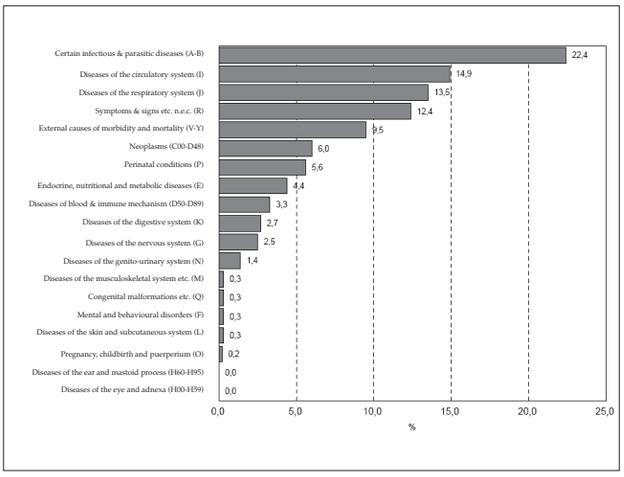

Fig. 1. Main groups of causes of death in South Africa in 2004 (StatsSA 2006).[1]

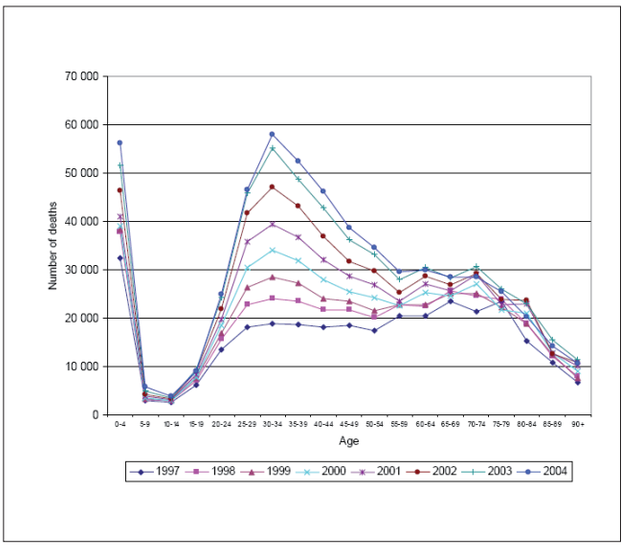

Fig. 2. Distribution of deaths by age and year of death (1997 - 2004).[1]

state 26 years into the HIV pandemic suggests that our response has been far from commensurate with HIV/TB's impact on burden of disease.

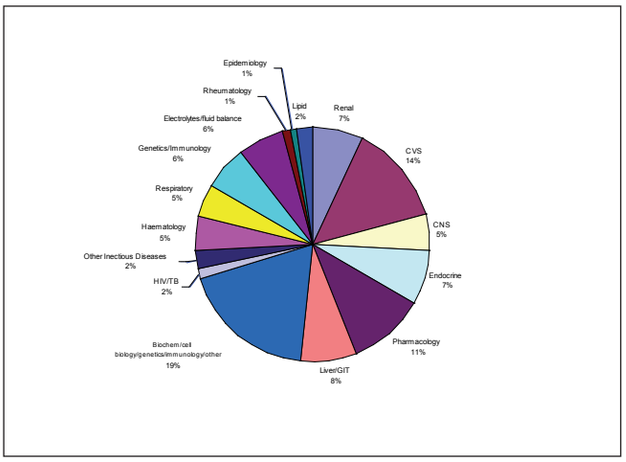

Fig. 4. Breakdown of all FCP Part I questions, 2001 - 2006 (CVS = cardiovascular system; CNS = central nervous system; GIT = gastrointestinal tract).

Given these facts, is it surprising that so many doctors in our public hospitals regard patients with manifestations of HIV/TB as an unfortunate chore? As medical registrars we are left with many questions. Do we have sufficient senior role models nurturing our interest in infectious diseases, encouraging us to accept nothing less than best national practice for these patients? Are we being encouraged and supported to investigate the vital and fascinating research questions on the pandemics sweeping our land? If we look at past papers can we honestly say that our study of HIV/TB is being adequately incentivised? Answers to these questions suggest that when it comes to evaluating our national response to HIV it is not just our emperor who is short of a few items of clothing.

Chris Kenyon
Groote Schuur Hospital
Observatory
7925
chriskenyon1@absamail.co.za

1. Statistics South Africa. *Mortality and Causes of Death in South Africa 2003 - 2004*. Pretoria: StatsSA, 2006. www.statssa.gov.za
2. World Health Organization. *World Health Report 2000*. Geneva: WHO, 2000. www.who.org

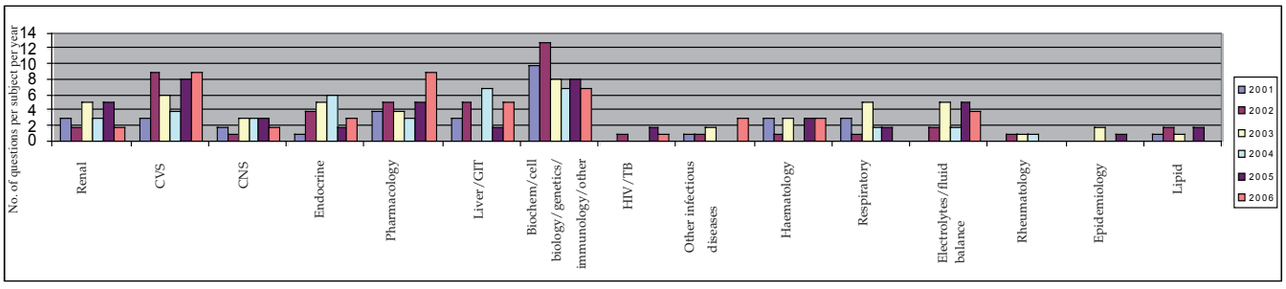

Fig. 3. Trends in questions in FCP Part I 2001 - 2006 (CVS = cardiovascular system; CNS = central nervous system; GIT = gastrointestinal tract).