SAFP NEWSROOM

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## Beware the Ides of March!

The ongoing medicines pricing dispute between the Department of Health (DOH) and private sector provider groups takes another turn on March 15 when the DOH appeals against the Supreme Court of Appeals ruling against the implementation of the Medicines and Related Substances Act 90 pricing regulations.

The DOH lodged its appeal with the Constitutional Court at the end of January to repeal the Appeal Court ruling.

In the same papers the DOH also requested that, in the event of the Constitutional Court deciding not to hear the appeal, the court grant the DOH a six-month grace period to enable it to do what would be required in order to comply with the appeal court ruling.

In the event of this happening the dispute will have been extended to well over a year since the regulations challenge led by the Pharmaceutical Society of SA, United SA Pharmacists and New Clicks failed in the Cape High Court in June to prompt this now extended appeal process.

## Payment process fund(er)mental problem!

Doctors in this country have an addiction problem. They have become addicted to payments from funders!

And this, according to SAMA chairman, Dr Kgosi Letlape, is one of the major obstacles in the path of good doctor/patient relationships: "If a funder doesn't pay a doctor, the doctor has to sue the patient! To me this is the fundamental problem in the doctor/patient relationship.

"To avoid these problems, the patient must pay the doctor and the funder must reimburse the patient. Is it that difficult? It is the patient's money, after all."

* Adding a rider to this, noted family practitioner, Dr Sam Fehrsen, posed the question: why call funders *funders*: "What are they funding? They are not funding anything! We should find another name for them such handlers of funds, or money – patients' money!"

Well-known Gauteng family practitioners, Dr Des Sonnenfeld (left) and Dr Sam Fehrsen were among the many delegates who attended the recent SAMA/Pfizer *Legislation and the Doctor/Patient Relationship* symposium at Caesars Convention Centre.

## Doctors need more political clout to benefit from legislation

Recent research conducted by the World Medical Association (WMA) among general practitioners and specialists in Europe, Canada, Turkey and South Africa, has revealed that South African doctors definitely see a need to be more active in the country's healthcare legislation process. Speaking to delegates about legislative effects on the doctor/patient relationship at a seminar convened jointly by the SA Medical Association and Pfizer at Caesars Convention Centre at the end of January, WMA secretary general, Dr Delon Human, stressed that doctors should not underestimate their power in the community.

"We as doctors have a powerful voice and should use it in getting the government government to increase healthcare resources," said the South-African born Dr Human. Dr Human was a local GP before moving to the WMA in Geneva eight years ago.

He explained that concerns expressed by South African doctors in the WMA survey included:

- Limited access to treatment
- Increasing regulation of doctors' choices interfering with the doctor/patient relationship
- Declining quality of care, brought about by
  a) Shortage of doctors, skilled personnel, compensation, time
  b) Government limitations on patient access and reimbursement for latest medicines
- Declining status/interest in the profession, expected to get worse.

"All this has resulted in a low morale. Nonetheless, it is encouraging that more than 90% of the local doctors in our survey recognized that they have to participate more in legislation processes," said Dr Human, adding that to do so they realized that they have to be more than healthcare providers. They also accepted that they needed direction and insight into becoming advocates and influential leaders of the healthcare system.

Many of the South Africa practitioners surveyed (75%) acknowledged that doctors historically have been difficult to organize into a political force that could influence government because they tend to act as individuals rather than in groups or associations.

"This must change, as it has with considerable success in other countries. Take Japan, for example. Among those present at a recent meeting of the Japan Medical Association were the emperor, the prime minister and two previous prime ministers. This just shows that if you have an influence over voters," Dr Delon concluded, "you will immediately have access to government!"

**Dr Delon Human (right) with Dr Kgosi Letlape and the evening's programme director, Dr Fazel Randera**

## Academy memorabilia sought

Dr Sam Fehrsen, Academy of Family Practice pioneer and former editor of *SA Family Practice*, is on the look-out for Academy memorabilia any of the members, past or present, may have.

"I'm putting together a dossier on the history of the Academy to commemorate our 25th anniversary and am particularly keen to get hold of old photographs," Dr Fehrsen told *NewsRoom.*

* Anybody who can assist Dr Fehrsen can contact him on 082 576-5326

## Pharma companies stick to newly legislated single exit pricing (SEP)

**PMA COO, Vicky Ehrich**

Until such time as resolve to the various medicines pricing regulations challenges has been reached, Pharmaceutical Manufacturers Association (PMA) member companies will be adhering to their single exit prices (SEPs). PMA membership comprises 22 companies representing just over half the business conducted by multinational pharmaceutical companies in the South African private sector.

A survey by the PMA among its members revealed strong support for retaining the lower prices already established for consumers amidst the confusion surrounding the challenges.

In an early February media statement to this effect, PMA chief operating officer, Vicky Ehrich, explained that the benefits of lower prices were passed on by manufacturers in the form of the SEP in June 2004 after it became illegal to discount medicines.

Effect of the single exit pricing system was to reduce the ex-manufacturer cost of medicine by 20% in the first year, amounting to a saving of R2,5 billion.

In his comments, PMA president, Dr Guni Goolab, said: "We expected that our members would remain committed to their published SEPs in the interests of the consumer and in the interests of stability in the market place during this period of uncertainty."

Full implementation of the pricing regulations by the entire distribution chain was required by August 2004. The regulations were subsequently challenged in the Cape High Court and the Supreme Court of Appeal by pharmacy stakeholders. The Department of Health's application for leave to appeal is scheduled to be considered by the Constitutional Court on March 15.

## Temporary head of MCC

**Humphrey Zokufa**

Humphrey Zokufa, the Department of Health's high profile director of pharmaceutical policy and planning during the Medicines and Related Substances Act Amendment deliberations in 2003 and 2004, has been appointed acting registrar of the Medicines Control Council (MCC).

His appointment has been described as a temporary measure to fill the position of previous registrar, Precious Matsoso, who is now with the World Health Organisation in Geneva.

# National Health Service should be ultimate result of transformation

South Africa's current healthcare system is not achieving the *equity and access to healthcare for all* objective set out at the dawn of the new democracy more than 10 years ago. "The existing institution, sector or system, is not working," SAMA secretary general, Dr Moji Mogari, said at the January SAMA/Pfizer *Legislation and the Doctor/Patient Relationship* symposium.

This country, he said, was no different to other developing countries facing such challenges as:

- Limited health human resources
- Skewed financial infrastructure
- A non-existent National Health System
- A non-existent Health Information System
- Limited ethical considerations Limited or no health facilities in rural areas.

Based on the fact that healthcare diminishes with decreasing income, Dr Mogari stressed that government intervention was imperative to normalize these situations.
According to our Bill of Rights, everyone has the right to have access to healthcare services; and the state must take reasonable legislative steps within available resources to achieve a progressive realisation of rights.

To achieve these objectives, Dr Mogari said that the following structural changes would be required:

1. A different funding system outside conventional medical aids
2. A legislative environment necessary to create the different funding system – *The Central Fund*
3. The creation of a single Health Information System which all providers of care and facilities will have to use or be compatible with
4. The creation of a uniform set of clinical guidelines and formulary (for the NHS)
5. The contracting (through licensing) of private providers and facilities to serve in the NHS.

"The new product, therefore, must be the National Health Service (NHS). Cornerstone of the NHS," Dr Mogari explained, "should be *free universal access at the point of service (GP or clinic or other provider), where a basic or universal package will be provided without hindrance (possibly at no charge) to all citizens."*

Concluding, the SAMA secretary general said that it was imperative that doctors, internally and externally, embrace the transformation agenda "so that there can be optimism".

## Letlape WMA president-elect

It has been announced that Dr Kgosi Letlape, chairman of the SA Medical Association, has been elected president-elect of the World Medical Association.

Incumbent president is American Medical Association executive, Dr Yank Coble, while outgoing secretary general is another South African, Dr Delon Human.

# Why transferring risk to providers works

**Dr Reinder Nauta**

Transferring risk to doctors is probably the only way of engendering a vested interest among doctors in keeping their patients healthy, Dr Reinder Nauta, CareCross md, suggested when addressing African Health Care congress delegates in Sandton.

In a talk entitled *Strategies for enhancing and maintaining the relationship between medical schemes and service providers,* Dr Nauta explained that risk transfer and the development of networks had become the latest products in what he called the risk management evolution. By-products, he explained, were capitation, designated service providers, provider partners and horizontal integration.

Taking a closer look at the benefits of transferring risk to providers, Dr Nauta was able to show the emergence of certain realities such as

a) The least busy doctors and emptiest hospitals are the most profitable ones
b) Excessive and unnecessary interventions cost the providers money and not the patient or medical schemes
c) Expensive technologies are liabilities to be used judiciously and were not assets to be exploited
d) Providers provide their own utilization management tools.

And as already pointed out, doctors have a vested interest in keeping patients healthy. Risk sharing, Dr Nauta added, made relationship building between schemes and providers a non-negotiable imperative in what had to be a partnership approach. On the provider side, he added, this would be best implemented via networks.

"Times are changing. Medical schemes will prefer to contract *en mass* and providers will have to compete for accreditation within networks, "said Dr Nauta.

"Designated service providers (DSPs)," he added, "will be quick and easy solutions for schemes." Other inevitabilities cited by Dr Nauta were that legislation would drive members into low-cost options, prescribed minimum benefits (PMBs) would increase and there would be more patient empowerment particularly when choosing their own and permanent doctor.

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## Suspension of new regulations poses problems for schemes

The confusion which reigns around the charges for medicines, dispensing and other services offered by dispensers of medicines has created serious financial posers for many medical schemes.

Board of Healthcare Funders (BHF) MD, Dr Penny Tlhabi, made this point when announcing that the legal opinion obtained by BHF from independent Senior Counsel supported the view which indicates that the regulations have been suspended until the Constitutional Court decides whether or not an appeal by the Department of Health will be granted at the March 15 hearing.

In the interim the BHF and other industry stakeholders are working on possible solutions which incorporate the principles contained in the Act, such as transparency, affordability and incentivising the dispensing of lower cost medicines.

Problems faced by the schemes arise out of the fact that the Medical Schemes Act prescribes a governance framework which every medical scheme has to comply with.

"Each medical scheme," said Tlhabi, "is bound by an individual set of rules approved by the Registrar of Medical Schemes. When the new regulations around medicine pricing were put into effect on May 2 2004, medical schemes had to register new rules with the Medical Schemes Council in line with the regulations which pertained to a single exit price plus the R26/26% dispensing fee. In the absence of any legislation, therefore, those rules apply."

Tlhabi added that medical schemes budget a certain amount for pharmaceutical benefits for their members in September each year: "And as the regulations were already in place last September, they budgeted in line with these regulations – regulations which introduced transparency in the pricing system which, in turn, meant lower cost medicines for the consumers, the incentive to dispense lower cost medicines and generics, and a professional fee for the pharmacist." An added financial burden for medical schemes and their members was being created by pharmacies not charging the same price for medicines and charging for a variety of services over and above the medicines price...

"In terms of the Medical Schemes Act, a medical scheme may only reimburse for 'relevant healthcare services', and since the administration costs charged by pharmacists do not fall into this category, it is extremely difficult for a scheme to cover these costs - except where they have been granted special permission by the Registrar to do so."

Tlhabi also expressed concern regarding some of the proposed models for charging.

"The problem with some of these models is that the cost of an average line item on a script would increase and that the pricing is structured in such a way that it removes the incentive for pharmacists to dispense lower cost products, which is contrary to what the Department of Health is trying to achieve in providing consumers with more affordable medicine."

## Fees rise with malpractice suits

Recent news reports emanating from an article in the *SA Medical Journal* have implicated a rise in malpractice litigation has prompted doctors to increase their consultation fees.

The Medical Protection Society (MPS) was reported to have increased its premiums by an average of 23% - obstetricians and gynaecologists bearing the highest at 43% and GPs the lowest at 13%, i.e. from R5300 to R6000.

Reason for this disparity, the *SAMJ* article noted, was that the likelihood of obstetricians being sued as opposed to GPs was 12 fold.

Nonetheless, a Johannesburg GP has apparently seen fit to increase her consultation fee by 33% to offset some of these increases.

## Bonitas claims exceed R3-billion mark

**Bongani Mncwango**

Having to process claims in excess of R3.0 billion and to collecting more for its largest medical aid client, Bonitas, has forced the country's largest administrator, Medscheme, to dedicate an entire administration division to Bonitas.

Bongani Mncwango, Medscheme managing director responsible for the Bonitas Fund Division believes one of the key competitive advantages of the scheme is its ability to process claims from its 204 000 principle members efficiently and seamlessly.

Established in 1982, Bonitas has full access to Medscheme's state-of-the art client service centres in all South Africa's nine provinces.

"Administering a scheme this large we realised that in order to remain competitive we needed to re-evaluate the way the processing was happening due to the sheer volumes coming through and pressure on our systems," said Mncwango when commenting on these developments.

A new emphasis on service and an improved administration system has enabled Bonitas to process more than 700 000 claim lines per month and EDI (electronic data interchange) claims amount to 90% of this total.

"We are currently exploring real time alternatives for the bulk of our claims as we strive to achieve even higher efficiency levels," Mncwango added.

The average call centre member service levels are at 92% and centre broker service levels at 94%, i.e. nine out of 10 member and broker calls received are answered within the first 20 seconds. The scheme has also seen advances in its refocused credit control policy to the point that a complete reconciling of all employer groups on a monthly basis has become a norm rather than an exception.

## ICD 10 Coding course for practitioners

The Foundation for Professional Development is running three ICD 10 Coding course modules designed to prepare healthcare providers for the pending implementation of the compulsory use of ICD 10 Coding in South Africa from July 1 2005.

The first module is a basic introduction to the ICD 10 system, which will not replace any of the existing procedural or billing coding systems but will be an additional system aimed at improving the quality of the country's healthcare data and information.

The other two modules, Medical Terminology and Anatomy, will be run together and will contain essential background information prior to learning ICD because of the technical nature of these codes.

The course modules are available either on a face-to-face tuition basis or in a distance programme, and will be CPD rated.

* Further information from course co-ordinator, Zukie Luwaca, on (012) 481-2076

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