



## Medicine pricing regulations: in or out?

The Department of Health, in lodging its appeal against the December 20 Supreme Court of Appeal of SA decision to uphold the various provider groupings' urgent application to set aside the medicine pricing regulations, with the Constitutional Court, has created considerable confusion regarding the interim status of the regulations.

The debate now raging is whether the regulations implemented on August 27 are still in place or not i.e. suspended or not while the Constitutional Court decides.

Until such time as this is resolved, the SA Medical Association has recommended that dispensing doctors revert to charging the same fees as they did prior to August 2004.

Judge Louis Harms is reported to have noted in his Supreme Court judgement that the regulations "have, on many material aspects, failed the test of legality. Sometimes problems arose as a result of the enabling act, sometimes it was because of a misunderstanding of the scope of the act".

While the court did not challenge government's right to prescribe prices, it appeared to be influenced by expert evidence that the margins set by government were so low they threatened the long-term viability of the retail sector.

The major issues argued during the appeal were whether the dispensing fees were 'appropriate' and whether the regulation of the single exit price (SEP) was legal. The court ruled that the Regulations relating to a Transparent Pricing System for Medicines and Scheduled Substances' as published in Government Gazette R553 on 30 April 2004, were invalid and of no force and effect.

In light of this judgement, the regulated prices of medicines (single exit price) and appropriate dispensing fees (16%/R16 and 26% and R26) were no longer legislated by the pricing regulations.

SAMA has also advised doctors to note that medical schemes only pay a benefit portion of the cost of medicine, which could differ from the amount at which medicine is dispensed. Different schemes usually pay benefits according to the option selected by the member (patient), and reimburse claimants accordingly.

## Medscheme completes mammoth claims processing conversion



Medscheme's IT department has completed what is believed to be one of the largest conversions ever attempted in the medical aid industry – decommissioning its traditional mainframe in favour of an Oracle database and a fully integrated system.

Since the process began early in June, the transition has resulted in the conversion of more than 4 000 000 member records as well as the processing of in excess of 101 000 000 claim records.

"Throughout the process, real time capabilities were maintained, enabling us to deal uninterrupted with the constant flow of healthcare transactions,"

Medscheme IT director, Kevin Wright, explained at the completion of the project.

The new NEXUS system integrates 14 modules, from the basic administration functionality to full e-communication via web, e-mail and SMS. Workflow, management reporting and interfaces with brokers as well as loyalty programmes have all been built into the system

"Medscheme has ensured this system is compatible with the likely demands of the impending Public Sector Medical Aid Scheme," Wright added.

### Morag Crease

Commenting on the new system, Medscheme COO Morag Crease said: "We believe IT excellence will increasingly become one of the key differentiators in the healthcare industry, particularly for a multi-scheme administrator like Medscheme where the flexibility and diversity of its IT capability and its ability to integrate and interface with other systems is critical.

"Gone are the days of medical aids taking several months to pay," she added, explaining that more than 95% of all electronic claims are now received and processed without human intervention, within five seconds.

## Quality of local scheme benefit options to be assessed from January 2005

A health quality assessment programme (HQA) has been developed by Deloitte & Touche, in association with the Board of Healthcare Funders (BHF), the Council for Medical Schemes (CMS), and the Consumer Council, to offer a ranking of South African medical scheme options on the basis of quality indicators.

The project was presented to medical scheme and allied organisation representatives by Deloitte & Touche executive, Emile Stipp, at a healthcare quality measurement seminar sponsored by Pfizer on behalf of the BHF in Sandton last month.

The programme is being conducted on a voluntary membership basis and is currently open to all medical schemes and administrators. ABSA Health, Discovery, Medscheme, Medihelp, Metropolitan Health, MxHealth, Multimed and Old Mutual Health had already enrolled as members by December 2004.

The HQA board includes representatives of the BHF, CMS and Consumer Council.

Explaining that HQA will publish quality assessment reports, commencing January 2005, Stipp gave the following reasons as to why health outcome measurements were now needed:

- Legislation encourages the formation of DSPs for PMBs – we need to measure the performance of networks
- We need to measure the health outcomes achieved under different protocols
- We need to measure the health outcomes achieved under different forms of managed care
- Measuring health outcomes removes the incentives for "diagnosis creep"

Categories of analysis will be *In Hospital – Surgical; Chronic Illness Management; and Primary Care.*

"Health quality measurement data," said Stipp, "is standardized by age bands using age profile collected for costing exercise to neutralize demographic differences among schemes. Only claims data will be used and mostly line items, so diagnosis is not necessary for most of members."

"Each participating scheme," he added, "receives a report comparing all their options against the industry. No scheme will see the results of other schemes, but all will see industry results.

"There will be one industry report and confidentiality of all participants will be protected."

## First steps taken towards CPD revision

The Health Professions Council of South Africa (HPCSA) has released its first draft proposal for a reconfigured Continuing Professional Development (CPD) system.

Most notable change is a move from passive to active learning with increased reward for active learning associated with measurable outcomes.

The proposed system, according to an HPCSA media statement, allows for a hierarchy of CPD activities to be viewed from a developmental perspective. Learning is structured from traditional didactic learning experiences such as conference presentations and lectures through to quality assurance programmes with formally constituted small study groups as an important component to meet specific local needs of practitioners throughout South Africa with measurable outcomes.

"This," the statement added, "will encourage service providers to use a broader base of CPD activities that will ultimately meet the goal of continuing education: namely improved patient care."

In the revised CPD programme proposed, every registered practitioner will be required to accumulate 30 credits per 12 month period. Credits allocated to CPD activities will be valid for a period of 24 months. In recognition of practitioners' participation in the current system, it is proposed that every practitioner will receive a starting balance of 30 credits, effective from the implementation date of the new system.

The reconfigured CPD system will be piloted by two or three Professional Boards in order to smooth out the implementation. Here the HPCSA has emphasized that the current CPD system will remain in place for Boards that are not involved in piloting the new system, as CPD remains an ethical as well as statutory obligation. The only deviation is that practitioners are requested not to submit their portfolios but to retain them for possible assessment.

\* The full draft document is available to all stakeholders on the HPCSA website: [www.hpcsa.co.za](http://www.hpcsa.co.za).

## Mx Health goes to court over Polmed

MX Health has been reported to be making a determined bid to retain its R300m three-year contract with Polmed following Metropolitan Health winning the tender to take over the Polmed administration.

It was noted in a December issue of *Financial Mail* that Mx Health claimed in court papers filed earlier in the month that the tender process and the awarding of the contract to Metropolitan Health featured several material irregularities as well as bias and a lack of procedural fairness. Polmed is one of the country's largest restricted schemes with about 350 000 lives. It was administered by Mx Health for the last three years until the end of December 2004 when its contract was due to expire.

Mx Health has now requested that the tender process, implemented by Polmed in August last year, now be reviewed urgently.

## Cost drivers identified in scheme increases survey

Research conducted by the Board of Healthcare Funders towards the end of 2004 has shown that the expected 2005 average medical scheme contribution increases for open and restricted-membership schemes will be 5,8% and 7,6% respectively.

In a media release announcing these findings, the BHF noted that the weighted average would be 6.1%.

The survey focussed on the major drivers in the contribution increases for 2005. Questions therefore referred to specific components of the increases including the building of reserves (solvency requirements), ageing scheme population, medical technology usage, benefit enhancement, prescribed minimum benefit list (including the chronic disease list), increases in administration costs, core medical inflation, utilisation creep, expected scale of benefit increases and supply induced demand (increased spending on providers).

The BHF went on to note that the primary components for contribution increase drivers for both open and restricted-membership schemes were core medical inflation, benefit enhancements outside of the PMB's and expected increased hospital spending (see table)

Components in Contribution Increase	Restricted-Membership*	Open Membership*
Building of Reserves (solvency requirements)	-5.8%	-4.3%
Ageing Scheme Population	0.1%	0.6%
Medical technology usage	0.0%	0.4%
Benefit enhancement	2.0%	3.6%
Prescribed Minimum Benefit List (including the Chronic Disease List)	2.2%	0.4%
Increases in Administration Costs	-1.3%	0.7%
Core medical inflation	0.7%	2.2%
Utilisation creep	0.9%	0.8%
NHRPL(SoB) Increases	2.9%	0.7%
Hospital Spend	4.4%	1.0%
Specialist Spend	0.5%	0.5%
GP's Spend	1.6%	0.3%
Pharmaceutical Spend	-0.2%	-0.4%
Other	-0.4%	-0.7%
Totals	7.6%	5.8%

Restricted membership schemes also felt that the increases published in the National Health Reference Price List (NHRPL) would have a significant impact on the contributions. As in previous years, schemes have cited open enrolment, community rating and open-ended benefits as having diminished the scheme's ability to manage risk adequately, accounting for the status quo - i.e. significant annual contribution increases.

## Cuban doctors – no more cigar smoking with SA government

Many of the Cuban doctors now working in South African public hospitals in terms of a 1996 government-to-government contract, are contemplating legal action against the South African government for discrimination and unfair treatment.

About 150 of these doctors, according to a media statement released by the SA Medical Association (SAMA) towards the end of last year, believe that aspects of the South African/Cuban agreement has not met expectations.

Their grievances in this regard include:

- Unilateral cancellation of contracts between Cuba and the doctors by the Cuban authorities;
- Termination of employment contracts by the Department of Health;
- Ignorance among Cuban doctors regarding the conditions of the contract between South Africa and Cuba;
- Inability of Cuban doctors to successfully apply for permanent residency;
- Restrictions imposed on Cuban doctors to write an examination to confirm registration with the Health Professions Council of South Africa after 10 years of service in the public sector.

## NEW YEAR'S MESSAGES

What will the year 2005 hold for the various medical groups and organizations, particularly after the legislative upheaval experienced during 2004? The following are some thoughts on the prospects from several organisation leaders and authorities...

### Significant, memorable year for Academy



**Dr Shadrack Mazaza, National Chairman, SA Academy of Family Practice/Primary**

There is little doubt that the year 2005 will be one of the most significant for the Academy in its 25-year history, and as such one of the most memorable. Aside from the many Academy initiatives and activities continuing to develop and grow from strength to strength, we will be celebrating the 25<sup>th</sup> anniversary of the organization. Fortunately it is a congress year for us, providing the ideal platform to celebrate this significant milestone – the 13<sup>th</sup> National Family Practitioners Congress will be taking place in Umtata in August.

On the academic front, we look forward to the Health Professions Council of SA ratifying Family Practice as a specialist discipline, thereby adding a new dimension to the function and status of the Academy.

As mentioned in my 2004 annual report, we have already had Prof Jannie Hugo leading the process of consultation and planning for the training of family physicians in collaboration with our FaMEC colleagues and associates.

We had workshops in Gauteng last year, with more to follow elsewhere this year. Hopefully this education process will both boost membership and add value for existing membership.

We can also look forward to the *SA Family Practice Clinical Skills Manual* being completed before year end.

Other challenges ahead include a new, revised Continuing Professional Development (CPD) programme, placing a greater emphasis on active rather than passive learning. Rewards, I believe, will be increased for active learning associated with measurable outcomes.

This is good news and will, no doubt, have a positive influence on our family physician education programmes and related activities.

Bearing in mind that the Academy accredits almost 80% of GP – or should I now say FP – CPD activities in South Africa, this will also represent quite a challenge to our accreditation committee.

Special mention must be made of the Academy's Rural Health Initiatives which are now playing an ever increasing role in improving healthcare delivery in the rural areas. We have been placing greater emphasis on these activities in recent years and I am sure 2005 will be the year when this bears the most fruit.

Finally, our Journal, *SA Family Practice*. This Journal has made giant strides in the last five years, to a level that it has been recognized by the Academy of American Family Physicians as a suitable medium to contribute one to two of its own AFP articles in each issue on a contractual basis.

This year we will also be seeing a special column on Contract Research Opportunities as well as a special news section up front which should prove most interesting. I am also told that we can expect more practice and financial management articles.

In conclusion, a year to look forward to – see you in August in Umtata!

### Year to strive for the right methodologies

**Dr Kgosi Letlape  
Chairperson, South African Medical Association**

Last year was a particularly unsettling year for the health sector in South Africa. Health care in 2004 was an adversarial environment characterised by protests on the health front, confusing legislation, continuous discord and the resultant court cases between the health sector and government.

The efforts by government to lower the price of medication is supported by the Medical Association. However, in 2005 we should strive for a methodology behind this that will improve the system and not serve to create paralysis.

What South Africa needs is a health system that can serve the basic health care needs of all citizens. There should be no payment at the point of service, and government should take on the responsibility of supplying the pharmaceuticals used at this point of service. Medical professionals need to be properly rewarded for the work that they do. In this way, we will retain our valuable professionals.

### Year 2005 will be 'Year of the GP'

**Dr Dennis Dyer, Chairman: SA Managed Care Co-operative (SAMCC)**

From inception the SAMCC has had as its goal to bring quality care to more people in our country. This goal has been the focus of our activities in 2004 and will remain the focus for 2005. It is easy to glibly make this statement and leave it as an ideal that is promoted as a fantasy. To make this a viable reality is an enormous task which requires infrastructure, expertise and commitment. It requires a committed group of providers caring at all levels - from the primary care level to all specialities, clinical and investigative as well as hospitals. Coupled to this is the need for a sound administration and management capability which together constitutes an integrated model to deliver care.

The existing fee-for-service financial model is escalating at an unsustainable rate and as such not only remains out of reach for most of our people, but is also becoming too expensive for many of those in the system.

The SAMCC is acutely aware of these concerns. In 2003 and 2004, the infrastructure and resources were identified and a process of organization and consolidation was set in motion. This process involves accreditation, equipping practices with the physical capacity to produce relevant data and educating staff and providers as to what is required to successfully participate in risk sharing financial models that will deliver quality care and ensure an appropriate professional remuneration. In 2005 this process will continue, building a competent network countrywide. This year will see the implementation of the first ventures and the SAMCC will be involved in the accreditation, management and review of the network ensuring that it is capable and functioning optimally.

The year 2005 also sees the fruition of years of work directed at better remuneration for GPs and entrenching the GP's role as custodian of the patient's health and healthcare budget.

We will continue to provide appropriate education, to communicate with authorities and to participate in all other activities which effecting our members to ensure competent representation on their behalf. We believe that 2005 will be the Year of the GP.

### Dispensing legislation challenge 'not in vain'

**Dr Norman Mabasa, Chairman: National Convention on Dispensing (NCD)**

The past year has seen the NCD embroiled in a legal wrangle over the validity, or constitutionality, of the dispensing legislation.

The application to declare the regulations null and void was dismissed by Acting Judge Kruger at the Pretoria High Court. Subsequently the NCD applied to the Constitutional Court to set aside the Pretoria High Court ruling.

The relief sought was, firstly, to declare some provisions in the regulations unconstitutional. This because, despite the fact that all doctors who applied for licenses were given their licenses, the possibility still remains that their licenses could be revoked upon re-application as there could be pharmacies in their proximity by the time they have to re-apply.

The second leg of the relief sought is to declare the cost order null and void as this is a constitutional matter where each party should be responsible for their own costs. The appeal was heard on November 11 2004. We await judgment which, at the time of writing, is still expected during January.

We still feel that our efforts were not in vain as everybody managed to get their licenses and to us this is a major victory – a situation which would not have transpired had we not challenged these regulations.

While exempt from the drug pricing war, the NCD welcomes the Supreme Court ruling in favour of pharmacists as this means everyone, including medical practitioners, will get a new opportunity to enter into negotiations with the Department of Health in order to arrive at a more reasonable solution regarding the issue of dispensing fees.

The way forward will be directed by events at the Constitutional Court where the DoH has applied for leave to appeal the Supreme Court of Appeal ruling. We await the outcome with keen interest and are now well prepared to negotiate an acceptable dispensing fee.