



LegalWatch

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J88 Forms (Hospitals and Health Professionals).



Several complaints have been laid with HASA, SAMA and the Department of Health in regards to users being denied access to their J88 Forms. In particular, users have reported that some health professionals are requiring fees for the completion of their J88 Forms, and in the absence of payment these forms are withheld. In addition, other users have reported that payment is required by the hospital and that failure to comply with payment conditions results in the J88 being withheld.

HASA members are informed that the J88 Form is an official State document used in criminal proceedings, and for this purpose falls within the jurisdiction of the Criminal Procedure Act. It is a form used almost exclusively for the purposes of recording injuries sustained by a user, and which may be used later in criminal proceedings. Neither health professionals nor hospitals are in the opinion of HASA authorized in any way to withhold these forms from users, and in the event that such is withheld such action may constitute a crime within itself. Members are reminded that any act which delays, obstructs or defeats any criminal charge or proceeding may constitute an offence in criminal law.

HASA is also of the opinion that neither hospital nor health professional may charge for the completion of these forms.

All charges which may be charged by either a hospital or health professional are restricted to those charges invoiced in accordance with the diagnosis, treatment and provision of health care services, and in no way should there be any additional charge for the completion of any State prescribed form. Furthermore, under no circumstances are these forms (J88) if completed by the health professional to be withheld by either the hospital or that health professional for any claim that may be outstanding in regards to the

user. Hospitals and health professionals are advised to address these claims separately against the user, and not withhold any J88 form against such claim.

National Health Act (Blood Transfusion Service)

Please note that section 53 of the National Health Act (set out below) came into effect on 30 June 2008.

Establishment of national blood transfusion service

53. (1) The Minister must establish a blood transfusion service for the Republic by granting a license to a non-profit organization, which is able to provide a blood transfusion service throughout the territory of the Republic.

(2) The holder of the license granted in terms of subsection (1)—

(a) must comply with prescribed norms and standards and must provide the prescribed blood transfusion and related services;

(b) may establish regional units, for the delivery of blood transfusion services, which must function under the control of the license holder; and

(c) has the sole right to provide a blood transfusion service in the Republic.

(3) Any person other than the holder of the license granted in terms of subsection (1) who provides a blood transfusion service in the Republic, is guilty of an offence and liable upon conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and such imprisonment.

National Health Amendment Bill and other legislation explained by Neil Kirby of Werksmans.

The Amendment was submitted to parliament for consideration on the 2nd of July 2008.

Below is an excerpt of Neil Kirby's speech at the HASA Conference. For those members that want a completed version, please request

such from Lindy Moss at contact@hasa.co.za

I can think of more than one cliché or platitude dealing with change. I'm sure you can as well. I'm supposed to deal with developments in healthcare legislation but that is like trying to explain why the chicken crossed the road and no doubt your visions will be better than mine. So, I decided to talk about change - fundamentally, we're dealing with massive sweeping changes to healthcare legislation: the Medical Schemes Act, the National Health Act, the Medicines Act, numerous sets of regulations and policy documents.

So, why the change? Change is apparently necessary to afford more people access to healthcare pursuant to government's obligations in terms of section 27 of the Constitution. How is this access to be achieved? Through legislative acts - requirements, obligations, controls, regulation and other peremptory measures. Therefore, we have changes to current healthcare legislation, which has already been amended - bear in mind - apparently; previous amendments fell short of the Constitutional directives of institutions like the Constitutional Court.

National Health Price Reference List Update.

As stated in our last LegalWatch Deloitte's were appointed to complete the HASA submission on the NHPRL. More specifically as the hospital sector (with the exception of Psychiatric Hospitals) had never participated in any reference pricing prior to the publication of the Reference List by the Department of Health, application was made for a new costing methodology for private hospitals in accordance with the applicable regulations.

In particular Regulation 3 of the aforementioned regulations specifies the information that may be submitted. Regulation 3(2) (a) requires the information to be submitted in accordance with a pricing methodology that is to be published together with the guidelines for the submission of information.

The guidelines published include only a pricing methodology (Item 3 of the Reference Price List Guidelines) which is appropriate to an operating environment such as a General Practitioner or Specialist practice but not for a capital intensive environment.

Item 3.6 of the Guidelines provides for "**Exceptional Situations**" as follows: "It is acknowledged that the costing methodology described in the document is not for all health care disciplines or service environments. This is particularly applicable to facilities such as hospitals, pathology laboratories and emergence services. If an intended costing methodology deviates substantially from the

methodology documented here, the methodology must be properly documented and submitted for approval prior to its use in costing studies for the RPL.

HASA is currently meeting with the Department of health to get that approval before costing all its data, and making such submission. Members will note that the Regulations themselves require such approval, and to date we have not had such approval from the Department.

Members will however, be kept informed of this process.

Payment in full for the PMB's?

The case of **SAMUWED vs PA** the matter of the PMB's and 'payment in full without co-payment' were deliberated on. In particular, the case concerned:

Regulation 8(2)(b) of the regulations promulgated under the Act provides that no co-payment or deductible is payable by a member of a scheme if a service in respect of a prescribed minimum benefit ("PMB") condition is involuntarily obtained from a provider other than a designated service provider ("DSP"). Regulation 8(3) provides that such a service will be deemed to have been involuntarily obtained if: 3(1) it was not timeously available from a DSP; 3(2) medical or surgical treatment for a PMB condition was required under circumstances or applications which reasonably precluded the beneficiary from obtaining such treatment from a DSP; or 3(3) there was no DSP in reasonable proximity.

An excerpt of the Ruling:

Firstly, the limitation of fees charged by service providers is not the function of the Council for Medical Schemes. That is the responsibility of the Health Profession's Council of South Africa (HPCSA), a body established specifically to regulate the practices of health professionals. By contrast, the Council for Medical Schemes regulates the relationships between Medical Schemes and their members. Although section 7(a) of the Act charges the Council with the responsibility of protecting beneficiaries, the remainder of section 7 makes it clear that this protection is in the context of the relationship between said beneficiaries and their medical schemes. One would have expected the word 'patients' to be used instead of 'beneficiaries', if the intention had been to intrude into the relationship between patients and service providers.....In the circumstances of the current appeal, however, the committee concludes that it cannot limit the fees that the Appellant is obliged to pay to the Respondent. To do so would simply shift the responsibility for the balance of the Respondent's fees to the Appellant's member, something which is expressly excluded by Regulation 8. In the circumstances, by operation of Regulation 8, the Appellant is obliged to

pay Respondent's account in full, and the appeal must consequently fail.

The full judgment can be accessed on the Council for Medical Schemes website, and members are advised to distribute this ruling to users which have had their accounts either rejected or partially paid by medical schemes.

The Medical Schemes Amendment Bill:

The Amendment Bill has finally been submitted to Parliament for consideration. The Amendment has been suggested to:

To amend the Medical Schemes Act, 1998, so as to amend and insert certain definitions; to provide for risk equalization among medical schemes; to provide for the establishment of a risk equalization fund; to extend the functions of the Council for Medical Schemes in relation to risk equalization; to provide for the application of risk equalization to medical schemes; to provide for the provision of information by medical schemes to the Council for Medical Schemes for purposes of risk equalization; to provide for the methodology and procedures for risk equalization; to amend the provisions relating to benefits and contributions provided by medical schemes; to amend the provisions relating to the composition of boards of trustees and eligibility of persons to serve as trustees or principal officers; to define the respective functions of boards of trustees and principal officers; to specify the powers of the High Court in relation to election processes; to amend the provisions relating to disclosure of trustee remuneration; to provide for good corporate governance guidelines and associated disclosure requirements; to amend the provisions relating to the powers of the Minister to make regulations; to amend the provisions relating to offences; to rearrange some of the existing sections; and to provide for matters in connection therewith.

In addition to considerations around the Risk Equalization Fund, the definitions pertaining to the 'business of a medical scheme' have also been changed. HASA notes that this seems to have been a late inclusion, as the first draft of the Amendment Bill did not have such a provision for a change of definition. We are of the opinion that this may be as a direct result of the **Guardrisk** judgment and the Council's position on short term health insurance.

HASA remains concerned about several sections within the proposed law, and has at length made submissions to the Department of Health in this regard. For some reason, these concerns seem to have not been adequately addressed. For this reason HASA will be making application to the Portfolio Committee to address such directly with those members. More specifically we believe that there such be more substantive control measures, as well as criteria applicable to the management of the Fund, and the fact that such a Fund is private

money and thus should be carefully held in trust (subject to qualifying criteria applicable to those members who have access to it, and who invest such on the members behalf).

Should members require a copy of the Amendment, please request such from Lindy Moss at contact@hasa.co.za or access a copy of such from www.gov.za

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