

SAMA INSIDER

JUNE 2016

J88: Are you allowed
to refuse?

Endocrine disruptors
and health



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

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EDITOR'S NOTE

JUNE 2016



Diane de Kock
Editor: *SAMA INSIDER*

It's your magazine

This month the *SAMA Insider* team have been pleased to receive so many contributions from readers – a positive re-inforcement that SAMA members are beginning to view this publication as their mouthpiece.

On page 4 SAMA President, Prof. Denise White, gives members feedback from the recent WMA Council session in Buenos Aires. She will elaborate on the issues that will be raised in our next edition. We welcome a contribution from Dr Solly Motuba on page 8 detailing how medical schemes reserves are accumulated and invested.

Prof. Shadrack Mazaza is a new contributor; his article about specialist family medicine physicians in private practice is on page 9. Endocrine disrupters and our health are the subject of Prof. Riana Bornman's article on page 11, where she maintains that as healthcare providers we have a responsibility to create awareness on endocrine disruptor chemicals and health effects. "It is evident that serious concerns cannot be disputed, but rather that the consequences may be more extensive than understood at present," says Prof. Bornman.

The follow-up article on the prevention of drug abuse on page 14 and 15 explains drug addiction and looks at how health professionals can assist in dealing with the problem.

Gert Viljoen's article on the special voluntary disclosure programme highlights how important it is for anyone needing to regularise their tax or exchange control affairs to understand this new programme.

May we take this opportunity to encourage readers to submit articles, write letters and prompt colleagues to make their voices heard on the pages of your magazine.

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The WMA meeting: Buenos Aires, April 2016



Prof. Denise White, SAMA President

The World Medical Association (WMA) is probably viewed by many doctors as a remote body whose relevance and value to SAMA members are uncertain.

Having recently returned from the WMA Council session in Buenos Aires, I consider this forum to be an excellent platform to give feedback about the meeting and to provide insight into important contributions of this organisation to the medical profession globally.

The WMA was founded in 1947 in Paris. The organisation was created to ensure the independence of physicians, and to work to attain the highest possible standards of ethical behaviour and care. This was particularly important to physicians after the Second World War, and therefore the WMA has always been an independent confederation of free professional associations. Funding is sustained by the annual contributions of its members (including SAMA), which has now grown to 111 National Medical Associations (NMAs).

The WMA provides a forum for its member associations to communicate and co-operate towards achieving and promoting consensus on high standards of medical ethics and professional competence, and to providing the professional freedom of physicians worldwide.

The purpose of the WMA is to serve humanity by endeavouring to achieve the highest international standards in medical education, medical science, the art of medicine and medical ethics, and towards providing equitable healthcare for all people in the world.

To this end it provides ethical guidance to physicians through its Declarations, Resolutions and Statements. These help to guide NMAs, governments and international organisations throughout the world, covering a wide range of subjects. These include an International Code of Medical Ethics, the rights of patients, humanitarian research, care of the sick and wounded in times of armed conflict, torture of prisoners, the use and abuse of drugs, family planning and pollution.

As an elected member to the Council of the WMA, SAMA enjoys a prominent role as a regular contributor and decisionmaker on global policy on a host of important socio-medical and ethical issues.

Meetings of the world body are scheduled bi-annually in different countries; and so it was that the 203rd session of the WMA Council, hosted in this instance by the Argentinian Medical Association, was convened in Buenos Aires (BA) from 27 - 30 April 2016. As President, I was privileged to accompany SAMA Chairman, Dr Mzukisi Grootboom, to this important international event.

Physician leaders at the meeting called for widespread advice to protect women and men who live in or must travel to Zika-affected areas

After the long and tedious flight to BA I soon discovered there was little opportunity to rest and recover from jetlag, let alone spend time at leisure or to do touristy things! Fortunately, I was treated to a magnificent bird's-eye view of the grandeur of the Argentinian capital and its daily hustle and bustle from my perch on the 18th floor of the hotel.

From dawn to dusk, colleagues from NMAs worldwide faced one another across long rows of chandelier-lit, damask-draped conference tables in the Sheraton Hotel

conference centre. With the assistance of a bank of translators and earphones clamped resolutely to heads, colleagues engaged in earnest conversation, for long hours, in multiple languages, on difficult socio-medical and ethical policy issues.

With a limited timeframe for face-to-face discussion and debate, the pressure was on for delegates to apply their minds to review, to revise, to reaffirm and to resolve a multitude of policies (many complex, some controversial) affecting the practice of medicine globally.

Prominent among these was the adoption by the WMA Council of a resolution on the current global health emergency caused by the devastating Zika virus.

Physician leaders at the meeting called for widespread advice to protect women and men who live in or must travel to Zika-affected areas and who are considering becoming parents. Advice should also be made available to pregnant women who may have been directly exposed to the Zika virus or whose partners live in, or have travelled to, Zika-affected areas. Delegates from 35 NMAs emphasised how important it was that physicians are kept up to date with the latest information on the levels of developmental and other abnormalities associated with the Zika virus.

The limited scope of this article precludes further input on other important and controversial topics discussed at the Council meeting and pertinent to the practice of medicine in South Africa, e.g. cannabis for medical use (proposed by SAMA), health databases and bio-banks, quality assurance in medical education and physician-assisted dying/euthanasia. Delegates at the meeting were urged to keep the global debate alive on these issues, in particular the latter. Notwithstanding the resistance to this topic and its divisiveness between countries, NMAs were encouraged to hold workshops on the matter in their respective regions.

It is my intention to elaborate on these issues in next month's *SAMA Insider* and to provide some context.

The WMA Council's resolution on the Zika virus can be found on the WMA website at: http://www.wma.net/en/30publications/10policies/30council/cr_31/index.html

J88: Are you allowed to refuse?

Marli Smit, Senior Legal Advisor: SAMA

The J88 form is generated by the Department of Justice and is the accepted document in terms of our legislation to be utilised in the South African Courts as the preferred method of adducing evidence in a criminal matter with regard to the injuries a complainant sustained in for example a rape, assault or attempted murder case.

It serves as a crucial piece of medical evidence in cases where interpersonal violence has taken place.

The Schedule 5-7 Offences as contained in the Criminal Procedure Act include indecent assault of children, rape and assault with the infliction of grievous bodily harm.

In order for these offences to be correctly investigated and the offenders brought to justice, the State requires that a J88 form be completed in accordance with the relevant legislative requirements which will see these offenders identified through correct forensic procedure and ultimately ensure that they are put in jail.

It is imperative that all doctors understand and acknowledge their responsibility in this regard.

The one question always asked is whether a medical practitioner is allowed to refuse to fill out the J88 form.

This is difficult to answer, especially when considering the person who requires the assistance of the medical practitioner when coming to the practice with a J88 form – this is usually someone who has been through a very humiliating and painful experience – on both an emotional and physical level.

Director-General of Health on completing the J88 form

The following extract was taken from communication received by SAMA some time ago:

“The Department of Health has received complaints that doctors in the private sector, mainly general practitioners assess and treat patients that have been assaulted – physically, sexually or otherwise – and then refuse to complete a J88 form to allow victims to institute prosecution.

The Department of Health appreciates the support to these victims by the private sector but wants to bring to their attention the following:

- The Charter for Victims of Crime in South Africa (legal consolidation) which clearly describes the rights of victims of crime.
- The Minimum Standards on Services for Victims of Crime. Although these documents

mainly refer to public health services, it also refers to “other service providers”.

You are also referred to the National Health Act, 2003 (No. 61) specifically sections 5, 10 and 13.

If doctors do not want to fill in the J88 if a patient attends a private facility, with police company or police referral, then doctors are obliged to complete the J88, they must stabilise the patient and refer to a centre, health establishment or service provider that will complete the J88.

If not, the service provider is denying the victim his/ her right to access the judicial system and is defeating the ends of justice. If a J88 is not completed, then the victim cannot lay charges.

Applicable legislation

The South African Constitution provides every person the right to equality, human dignity, freedom and security of the person and healthcare – last mentioned clearly confirming that no person may be refused emergency medical treatment.

The National Health Act further refers to the fact that no healthcare provider may refuse a person emergency medical treatment and that the obligation to keep records is subject to the National Archives of South Africa Act, as well as the PAIA Act, which indicate the right of every patient to have access to their own health records.

Are medical practitioners allowed to refuse?

How do we place these rights in context with the situations which medical practitioners are sometimes faced with when being approached by patients to complete a J88 form?

There are instances where a medical practitioner can refuse to examine a patient and subsequently fill out a J88 form, this would include circumstances where the medical practitioner is dealing with a medical emergency and is not able to examine the patient accordingly, or where the medical practitioner is of the view that they do not have the relevant and necessary experience or expertise to assist the patient accordingly.

There is a thin line between right and wrong. What is clear, is that the content of the form should be of the highest quality in terms of accuracy and thoroughness.

The more legible, complete and comprehensible the submitted J88 form is, the less likely the chances of having to testify in court.

The principles for correct completion of the J88 form include that the patient should give informed consent by means of a signed and witnessed form SAP 308, which must be *retained by the doctor in the patient file*. This consent is both for the examination and permission to hand the completed J88 form (which is confidential medical information) to the police for investigative and court purposes. The whole report must also be completed in the doctor's own handwriting and every page must be signed by the doctor.

The exhaustive requirements for specific details and accurate descriptions of what the medical practitioner observed and found during the full medical examination result in most practitioners shying away from becoming involved in the process.

At no time can a medical practitioner refuse emergency medical care to a patient, but they are allowed to refer the patient – if clinically stable and in no imminent danger of medical collapse – to another practitioner or treating facility if they are of the view that the patient's rights in this regard will be best served by another practitioner and facility with the necessary experience and equipment, etc.

Conclusion

The ultimate reason for refusal to complete the J88 or become involved in the process, directly links with the fact that the medical practitioner not only has to fill out the form, which takes a lot of time and requires substantial and specific information, but also the fact that they will be required to testify in court on their findings at the time of doing the medical examination and completing the form.

This can result in a person not receiving the protection from and before the law, which is a fundamental human right in terms of the South African Constitution. According to the information the Director-General provided, a medical practitioner in private practice is allowed to refer the patient to a health establishment or service provider that will complete the form (e.g. public hospital) – the prerequisite for this referral is that the patient must be stabilised. We do however encourage all medical practitioners to assist with filling out the J88 form as far as possible.

Employment contracts: Medical practices

Julian Botha, Strategic Accounts Manager: SAMA Private Practice Department



In operating a private medical practice, the general practitioner or the specialist of necessity employs staff to administer and ensure the smooth running of their practice. Certain functions are usually outsourced, but it would seldom occur that a medical practice functions without administrative staff.

As an employer, it is incumbent on the practitioner to adhere to labour legislation. This is not only to ensure adherence to the law, but also to ensure that one does not fall foul of the law and end up spending time and money defending a labour matter brought by an aggrieved employee. This is most certainly a case of "prevention is better than cure."

A myriad of provisions in labour legislation delineate the rights and obligations arising from an employer and employee relationship. It would be impossible to cover all aspects of this relationship in a single article.

At the outset, we need to define the concept *employee* and further distinguish it from and independent contractor.

The Labour Relations Act defines an employee as:

- (a) any person, excluding an independent contractor, who works for another person or for the State and who receives, or is entitled to receive, any remuneration
- (b) any other person who in any manner assists in carrying on or conducting the business of an employer.

Paragraph (b) of the definition was intended to prevent employers from evading the provisions of labour legislation by concluding contracts which would be considered as independent contractor contracts as opposed to employment contracts.

As with the majority of contracts in South African law, there is no requirement for an employment contract to be reduced to writing in order to be valid. However, it is recommended that the employment contract be reduced to writing in order to ensure that both parties are clear on the terms and conditions of the agreement as well as understanding what their rights and obligations are.

When employing staff in your rooms it is always advisable to have a written agreement signed to indicate that both parties accept certain terms and conditions as negotiated/agreed upon between the two parties. Although it is not a legal requirement to sign an employment contract, it is a requirement of the Basic Conditions of Employment Act, that the following particulars be provided to the employee in writing:

Section 29 BCEA

- "(a) the full name and address of the employer;
- (b) the name and occupation of the employee, or a brief description of the work for which the employee is employed;
- (c) the place of work, and, where the employee is required or permitted to work at various places, an indication of this;
- (d) the date on which the employment began;
- (e) the employee's ordinary hours of work and days of work;
- (f) the employee's wage or the rate and method of calculating wages;
- (g) the rate of pay for overtime work;
- (h) any other cash payments that the employee is entitled to;
- (i) any payment in kind that the employee is entitled to and the value of the payment in kind;
- (j) how frequently remuneration will be paid;
- (k) any deductions to be made from the employee's remuneration;
- (l) the leave to which the employee is entitled;
- (m) the period of notice required to terminate employment, or if employment is for a specified period, the date when employment is to terminate;
- (n) a description of any council or sectoral determination which covers the employer's business;
- (o) any period of employment with a previous employer that counts towards the employee's period of employment;
- (p) a list of any other documents that form part of the contract of employment, indicating a place that is reasonably accessible to the employee where a copy of each may be obtained."

"(3) If an employee is not able to understand the written particulars, the employer must ensure that they are explained to the employee in a language and in a manner that the employee understands.

"(4) Written particulars in terms of this section must be kept by the employer for a period of three years after the termination of employment."

It must be noted that where an employer employs less than five employees, the requirements in sections 29 (m), (n) and (o) do not apply.

It must be emphasised that the contract of employment should be as detailed as possible, and not merely adhere to the information that is prescribed by the legislation.

It will occur that employees in a medical practice will have access to confidential medical information. The employee must also maintain the confidentiality of the information. The vast majority of employees in medical practices are not registered healthcare practitioners and are not personally bound by the provisions of the Health Professions Act and regulations. In addition should a breach of confidentiality occur by the conduct of an employee, the employing practitioner will be vicariously liable and may have litigation taken against him/her.

It is therefore imperative for the employing practitioner to make provision in the employment contract for a confidentiality clause in terms of which the employee confirms that they must maintain patient confidentiality.

This will become even more pertinent when the Protection of Personal Information Act comes into effect. In terms of this Act, the incorrect and non-compliant processing of personal information (which includes health information) carries with it significant penalties.

It is highly recommended that proper legal advice be obtained in crafting employment contracts for staff. If proper and comprehensive contracts and policies are in place in your practice, many unnecessary disputes and litigation can be avoided. The use of "template" employment contracts which are downloaded from the Internet poses risk – these contracts are not necessarily comprehensive or appropriate to employees in a medical practice.

Birth of the Spring Foundation at Lentegeur Hospital

John Parker, *Spring Foundation*

In the modern era, it has become clear that most mental illnesses respond positively to treatment, and the philosophy of recovery in mental health has shown that even with the most severe of mental illnesses, people can and do recover if conditions are right. These conditions include a sense of hope, reconnection with society, empowerment, a holistic approach to healing and services that focus on developing the strengths and potential of each individual as much as on treating symptoms. It has also become clear that mental problems cannot be separated from the social environment and that healthier societies are essential to preventing mental disorders.

It is with this in mind that the concept of the Lentegeur Spring Foundation arose. Translated, *Lente geur* means “the aroma of spring” and symbolically spring epitomises the rebirth of hope after winter. The concept refers to the rebirth of hope through reconnection, a reconnection that has multiple dimensions: between humans and nature, between individuals in hospital and broader society, between communities and between us and our heritage.

The aim of the Lentegeur Spring Foundation is to bring alive a vision of the hospital as a leading, sustainable mental health centre at the heart of its community fostering the reconnection. This vision is shared by many in the hospital community, be they staff members, patients or carers.

The Foundation has been developed as a vehicle that welcomes and nourishes innovation, stimulates ideas and helps these grow from dreams to reality.

It is an organisation which has developed from the Spring Project which was part of the Cape Town World Design Capital 2014 programme. The foundation’s greening project was adopted as a flagship by the Provincial Department of



the Western Cape and the Premiers 110% Green Campaign.

It is now a fully registered NPO and PBO that is using a range of psychosocial rehabilitation and outreach projects to re-establish a sense of hope and recovery through reconnection to the natural world, community, identity and heritage.

The work of the foundation is transforming the way that the hospital and mental illness are seen by the communities it serves and providing a stimulus for the regeneration of these communities by the restoration of hope and identity.

The Foundation has been designed so that it can assist in establishing sustainable projects to attain the spring vision, raise the funds to make these happen and implement monitoring and evaluation systems to make sure they survive and grow.

Current projects

One of the projects at the hospital is the Market Garden, a first of its kind in South Africa. It is a farming development among the psychiatric patients at the hospital to regenerate the land, grow healthy food and heal the people involved.

The core focus of the project is to enable the psychiatric patients at the hospital to become experienced market gardeners who are able to re-enter society as a result



of being healed through their work on the land and who are now equipped to offer their community skills that make them an asset.

The access to fresh produce with a high nutritional value, produced locally, is a cornerstone to any community’s health and wellbeing. Market gardening offers realistic solutions to enable marginalised communities to grow as much of their fresh produce as possible using ecological methods.

The market garden boasts 4 years of exponential success and its increasingly fertile output enables it to operate as a productive and economically viable business unit. The patients are involved in growing, harvesting, packaging and marketing the gardens’s organic produce within the hospital and to selected local restaurants under contract.

Background

Lentegeur Hospital is one of three major psychiatric hospitals in the Western Cape, serving as a referral centre for one third of the province’s population. The hospital has a total of 722 beds and consists of two sections: Psychiatry and Intellectual Disability. Every month the hospital admits and successfully discharges over 100 patients, from all sectors of the population, and it also serves as a teaching hospital.

Originally commissioned in 1984, for psychiatric patients classified as “coloured” under apartheid, the hospital occupies a large site in the impoverished suburb of Lentegeur. To the public eye, it resembles many similar institutions from a bygone era, with anonymous buildings, in empty grounds, surrounded by high fences, symbolising the concept that mental illness was incurable and those suffering from it should be removed from society permanently. As such, in its current form it carries very powerful negative symbolism associated with oppression and a loss of identity.

Medical schemes unmasked

Dr Solly Motuba, Head of SAMA Private Practice Department



How medical schemes reserves are accumulated and invested is something of an enigma to most medical practitioners. This is not surprising, given the complex nature of the structure and the workings of medical schemes. The general thinking is that medical schemes are for-profit organisations and that they sometimes withhold payment in order that they may accumulate profits.

The truth is that medical schemes are not for-profit organisations and are predicated on the principle of social solidarity – where the young subsidise the old, the healthy subsidise the sick and the wealthy subsidise the poor. Nothing more and nothing less. The fact that their administration is often outsourced to third party administrators (TPAs) – which are for profit – is a discussion for another day. The discussion that follows is aimed at unravelling the enigma.

What are reserves?

The words “reserves” and “accumulated funds” are often used interchangeably and refer to the same thing.

Regulation 29 of the Medical Schemes Act No. 131 of 1998 makes provision for medical schemes to accumulate up to a minimum of 25% (10% in year 1, 13.5% in year 2, 17.5% in year 3, 22% in year 4 and 25% in year 5) of the gross annual contributions, to serve as reserves. 25% translates into an equivalent of 3 months’ contributions (3 months/12 months equals 25%). This is to ensure that the medical schemes will be able to withstand periods

of unfavourable claims ratios. For instance schemes with adequate reserves are able to withstand sporadic outbreaks and pandemics (e.g. influenza, Zika and Ebola).

How are reserves accumulated?

Medical schemes are constantly having to contend with a balancing act that is predicated on the following formula: contribution income + investment income > total claims + non-healthcare expenses (NHE).

It is only when the combination of contribution income and investment income exceeds that of claims and NHE that reserves get accumulated. The reserves get depleted when the situation is reversed. It is therefore in every scheme’s interests to ensure that their products and options are properly costed, there is good investment performance, claims are low and non-healthcare expenses are brought to a minimum.

It is common knowledge that medical schemes apply strict underwriting to minimise chances of attracting high-risk members – this flies in the face of social solidarity principles that were intended with the promulgation of the Medical Schemes Act. They scrutinise claims, under the guise of curbing overservicing, overutilisation and fraud. Stringent claims adjudication is therefore key to their accumulation of reserves. However, they cannot NOT pay claims and they are also compelled to settle claims within 30 days of receipt (Section 59(2)). Unduly withholding payment of claims is therefore illegal.

The problem is that some schemes tend to be overzealous in their approach to claims management, to the extent of employing draconian measures when dealing with claims that have been spewed out as suspect by the rules engines that have now become the *sine qua non* of claims administration and adjudication systems.

NHEs are made up of managed care fees, administration fees, trustees fees, marketing fees and salaries. According to the Council for Medical Schemes 2014/2015 Annual report, NHEs accounted for about 12% of the total medical schemes industry expenditure in 2014.

How are reserves invested?

Reserves, once accumulated, are invested in line with Regulation 30 and Annexure B of the Medical Schemes Act. This is to ensure that the investment risk is spread, investment performance is safeguarded and that funds are available at short notice as and when required.

Annexure B provides for investment of reserves in the following asset classes:

- Cash deposits – based on set risk criteria for banks (inside and outside the country)
- Bonds and bills
- Immovable property
- Shares and unit trusts
- Debentures
- Policies

None of them is dedicated to healthcare and related initiatives. This is in spite of the reserves being wholly medical schemes owned.

Food for thought

As at the end of 2014, there was about ZAR40 billion in accumulated reserves for all schemes. The investment thesis as outlined in Regulation 30 makes for provision for investment of these assets using instruments that are not directly beneficial to the healthcare industry. Money derived from the healthcare industry is used for vehicle finance, housing finance, mergers and acquisitions.

Would it not be more prudent for Regulation 30 to make provision for dedication of part of this funding, for exclusive use of healthcare ventures? Our view is that there is a compelling business case for some of the accumulated reserves to be used for the funding of the healthcare infrastructure.

The Government Employees Pension Fund (GEPF) has proven through the establishment of Public Investment Corporation (PIC), that it can be done. It is common knowledge that PIC now controls more than a trillion rand of funds.

The Department of Health should amend Regulation 30, to make provision for the establishment of a dedicated private equity fund for healthcare infrastructure. After all, it is the very infrastructural challenges that are beginning to impact on the country’s health outcomes. Such a fund could help provide capital expenditure, with operating expenses being used to service the loans and thereby providing guaranteed investment returns to schemes.

Specialist family medicine physicians in private practice

Prof. Shadrick Mazaza, SAMA Board member and Chair of Specialist Private Practice Committee

When the Health Professions Council of South Africa (HPCSA) registered the discipline of specialist physicians in family medicine, the doctors who got on to the new register were required to apply for a specialist private practice number from the Board of Healthcare Funders (BHF). This meant the doctors who previously had a general practice number (014) were issued with a specialist in family medicine practice number (015). These physicians started to submit their claims to medical schemes using the 015 practice number as specialists in family medicine and expect an appropriate consultation fee.

Some medical schemes responded by rejecting the claims and continued to remunerate the doctors as general practitioners (GPs). When the BHF were approached, they reiterated that their role was to issue appropriate practice numbers to physicians so that medical schemes could be guided by this to determine appropriate consultation fees. As a result of this problem, specialist physicians in family medicine were forced to continue submitting claims using the 014 practice number for general practitioners or the schemes simply ignored the 015 practice number and continued to treat these doctors as general practitioners.

Attempts to resolve this matter with medical schemes have been unsuccessful for some years. In November 2015, this matter was brought to the attention of the Director General at the National Department of Health. The SAMA Executive Committee shortly thereafter, had a meeting with the Council for medical Schemes (CMS), the body responsible for the practice conduct of medical schemes and administrators. The CMS said they are empowered to act only if evidence of rejected claims by specific medical schemes is provided to them. It was therefore agreed that all specialist physicians in family medicine were to submit all their claims to medical schemes using their appropriate 015 practice number, from 1 January 2016. Any rejections

arising thereafter were to be brought to the attention of the CMS for investigation.

In December 2015, the private practice division of SAMA wrote to all medical scheme administrators informing them of this decision. To assist the medical schemes in their determination of the level of consultation fees for the discipline, it was pointed out that the fee should be at a level of consulting specialist physician, this being a consulting discipline.

The ruling of the Competition Commissioner at that time has meant that SAMA cannot get involved in actual fee determination with funders

As a result of the a dispute between SAMA and the National Department of Health about 5 years ago, the Relative Price List (RPL), which the Department of Health used to publish to provide the medical schemes and medical practitioners with "benchmark fees" guidelines, was stopped. Further to this, the ruling of the Competition Commissioner at that time has meant that SAMA cannot get involved in actual fee determination with funders. This has left a vacuum in fee determination leaving the individual medical schemes to do the determination and engage directly with medical practitioners or their business formations.

Specialist family medicine physicians in private practice therefore need to organise themselves to engage with funders about

their consultation fees. The Academy will support its members and is forming a dedicated private practice committee to guide them in this.

The Academy recommends the following:

- All registered specialist family medicine physicians in private practice who have not applied for a specialist practice number with the BHF should do so.
- Registered specialist family medicine physicians in private practice who have a BHF 015 specialist practice number but have been submitting their claims to medical schemes as GPs (014), should do all their submissions using their specialist 015 practice number.
- Any rejections of claims by medical schemes on the basis of apparent non-recognition of you as a specialist should be referred to the CMS.
- Engage with the Academy on any problems you encounter so we can support you in your practice.
- Contact SAMA and give us your contact details so we can communicate with you about any developments. We particularly want to have the exact numbers of specialist family medicine physicians in full-time practice.

The SAMA Private Practice Committee of the Academy will deal with all matters pertaining to private practice and is tasked to formulate frameworks for the private practice of specialist physicians in family medicine. This includes:

- Remuneration and engagement with medical schemes
- Relationship with other family doctors in private practice (GPs, family physicians who are not specialists) and relationship with other specialist disciplines
- Patient referrals between disciplines
- Specialist physicians in group practice with other non-specialist family doctors
- Contracting arrangements with medical schemes and provider networks.

Unpacking commuted overtime, leave, replacements and sick leave

Modisane Lelaka, *Industrial Relations Advisor*

Commuted overtime has on many occasions posed a challenge and there is also confusion about whether commuted overtime should be paid while an employee is on leave or not.

Commuted overtime is explained as additional hours of work required by the employer to render services to the public. These hours are in addition to the core hours (40 hours).

Can an employee be paid commuted overtime while on leave?

Medical personnel who perform commuted overtime with approved contracts are remunerated for commuted overtime while on annual leave. The payment is dependent on the years of service, e.g. 30 days for 0 - 20 years of service and 36 leave days for 10 - 15 years of service.

However, commuted overtime is not paid to employees who are on sabbatical, special, sick, maternity or incapacity leave. It often happens that employees on maternity, incapacity or sick leave perform commuted overtime with the expectation that they should be remunerated. In terms of section

25 of the Basic Conditions of Employment Act, employees on maternity leave can only return to work after 6 weeks unless their doctor or midwife has given them permission to do so. Some employees on incapacity or sick leave also tend to perform commuted overtime. Members should avoid working commuted overtime while on maternity, incapacity or sick leave. The auditor general often detects such practices and gives the employer a qualified audit for overpayments.

What happens when payment has been made while on sabbatical, special, sick or maternity leave?

Any payment made erroneously to an employee's salary is regarded as overpayment. The employer recovers this overpayment in terms of section 38 of the Public Service Act. However, the employee first needs to be informed about the overpayment.

Arrangements should be made with human resources for repayment until all the money is recovered. Arrangement can be made for monthly instalments deducted from the employee's salary.

Employer requests the sick employee to find replacement while on sick leave

Firstly, it should be noted that it is not by choice that an employee gets sick. When an employee reports sick, it automatically means that the employee is temporarily incapacitated and unable to report for duty. The employee however, has a duty to inform the supervisor as soon as the employee becomes aware that he or she cannot report for duty. This is to afford the supervisor an opportunity to find a replacement. It is not the responsibility of the employee to find a replacement while on sick leave.

However, it is the responsibility of the employee to inform the supervisor about the period of absence. The employer also has a responsibility to ensure that service is rendered to the public by ensuring that there is enough staff to cover services until the employee has recuperated and is able to report for duty. The replacement of the employee should therefore rest with the employer/supervisor and not the sick employee. There is currently no law which stipulates that the employee on sick leave should find a replacement. Members are encouraged to seek assistance from SAMA in cases where they receive resistance from managers.

Letters to the Editor

The **Letters to the Editor** page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 300 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- subject matter must be pertinent to healthcare delivery
- should be submitted before the tenth of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, dianed@hmpg.co.za



Endocrine disrupters and health

Prof. Riana Bornman, School of Health Systems and Public Health, University of Pretoria Unit for Environmental Chemical Pollution and Health

As medical practitioners, we are faced with, among others, a diversity of challenges, realities and difficulties on a daily basis. We are expected to make correct and indisputable decisions about the health of people; more often than not, without the luxury of time to ponder on the decisions.

It is, therefore, not surprising that many decisions on our own health are decisions on what we really ingest by what we are eating and drinking or using for personal care are often not informed decisions as we may not regard them as serious matters. The same applies to our own perceptions and awareness of matters concerning the environment and health.

Empty bottles and cans on street sidewalks, overfilled waste containers along the streets, especially in the central business areas of towns and cities, and the impact of striking waste removal workers are easily recognised as environmental issues that may affect people's health.

On a completely different scale lies the implications of exposure to environmental endocrine disrupter chemicals (EDCs). There is little awareness that we are being exposed daily when making health decisions while choosing food and drinks, how these are produced, processed and stored; the insecticides we use in our homes and how we apply them; the possible effects of over-the-counter drugs; and many more.

On this subliminal scale, environmental pollution and human exposure to EDCs has been going on for many years and only in the early 1990s did the effects on human health, and in particular on the developing fetus, begin to come clear.

An endocrine disruptor is defined as, "... an exogenous substance or mixture that alters the function(s) of the endocrine system and consequently causes adverse health effects in an intact organism, or its progeny, or (sub) populations."

Exposures to exogenous compounds (EDCs) can mimic or antagonise hormonal systems and change the developmental trajectory. Depending on timing of exposure, nature of the EDC, and its levels, an adverse outcome may be evident at birth, or there may be a latent disease outcome. Developmental

Origins of Health and Disease (DOHaD) have been associated with latent effects of EDCs on every endocrine system studied to date.

EDCs are a heterogeneous group of molecules and include industrial solvents/lubricants, flame retardants, aluminium can linings, plasticisers, pesticides, fungicides and pharmaceuticals.

Environmental pollution and human exposure to EDCs has been going on for many years, and only in the early 1990s did the effects on human health, and in particular on the developing fetus, begin to come clear

Two authoritative publications recently focused attention to the adverse health effects of EDCs. *The State of the Science on Endocrine Disrupters Report* (2012) provides the global status of scientific knowledge on exposure to and effects of EDCs on humans and wildlife. Effects on early developmental phases of both humans and wildlife are of particular concern, as these effects are often irreversible and may not become evident until later in life.

Many endocrine-related diseases and disorders are on the rise. These include large proportions (up to 40%) of young men in some countries with low semen quality and increased incidence of genital malformations, such as non-descending testes (cryptorchidism) and penile malformations (hypospadias), in baby boys.

Pre-term birth and low birth weight, and neuro-behavioural disorders associated with thyroid disruption, have increased over past decades. Global rates of endocrine-related cancers (breast, endometrial, ovarian, prostate, testicular and thyroid) have been increasing over the past 40 - 50 years.

There is a trend towards earlier onset of breast development in young girls in all countries where this has been studied. This is a risk factor for breast cancer. The prevalence of obesity and type 2 diabetes has dramatically increased worldwide over the last 40 years. The World Health Organization (WHO) estimates that 1.5 billion adults worldwide are overweight or obese and that the number with type 2 diabetes increased from 153 million to 347 million between 1980 and 2008.

Close to 800 chemicals are known or suspected to be capable of interfering with hormone receptors, hormone synthesis or hormone conversion. However, only a small fraction of these chemicals have been investigated in tests capable of identifying overt endocrine effects in intact organisms.

The vast majority of chemicals in current commercial use have not been tested at all. This lack of data introduces significant uncertainties about the true extent of risks from chemicals that potentially could disrupt the endocrine system; disease risk due to these chemicals may be significantly underestimated.

The second publication, *Endocrine Review*, provides strong evidence of endocrine disruption linked to obesity and diabetes, disorders of female and male reproduction, hormone-sensitive cancers in females, prostate and thyroid tumours, neuro-developmental and neuro-endocrine system impairment.

This evidence was accumulated over a relatively short period of 5 years since the previous report was compiled. It is evident that serious concerns cannot be disputed, but rather that the consequences may be more extensive than understood at present.

As healthcare providers we all have a serious responsibility to our patients, ourselves and our children to create awareness of EDCs and related health effects.

SAGE summit facilitates communication

Diane de Kock

On 24 February this year 61 participants attended a summit for the South African Guidelines Excellence Project (SAGE). The purpose of the meeting was to facilitate dialogue between stakeholders involved in guideline activities including development, implementation and use, and research in South Africa (SA), and to explore future guideline initiatives.

Objectives

- To provide a platform for dialogue between role players
- To facilitate sharing of current guideline activities
- To provide an opportunity for networking of role players
- To explore perspectives on a national guidelines initiative.

SAGE

SAGE aims to enhance the quality of primary healthcare by engaging in a stakeholder-driven process to improve the standards of local guideline development, adaptation, contextualisation and, ultimately, implementation (<http://www.mrc.ac.za/cochrane/sage.htm>). Project SAGE has been made possible as a result of a three-year (2014 - 2016) flagship grant from the South African Medical Research Council (SAMRC).

Summit programme

The Summit included a pre-conference workshop on 'GRADE for Guideline Developers' on 23 February 2016. This was led by Prof. Holger Schünemann from McMaster University, with local co-facilitators, Dr Nandi Siegfried and Dr Tamara Kredo. The talk was fully subscribed and attended by 32 participants, including delegates from government, academia, public and private healthcare. Prof. Schünemann introduced the principles of guideline development, adoption and adaptation. He used practical exercises based around a framework for moving from evidence to recommendations within guideline work using the GRADE approach. Both online and paper-based approaches were demonstrated.

The main summit on 24 February 2016 created an opportunity to meet with others working in this field and provided a platform to share and discuss both development and



implementation of guidelines in SA. This was achieved with rapid-paced, multi-sectoral panels that discussed experiences and best practices in guidelines development and implementation in our setting. Group work and open discussions allowed those present to voice challenges and identify solutions to enhance current guideline activities in SA.

During the discussions a number of recommendations were made, including the following functions that were identified for a National Guidelines Coordination Unit:

- Provide leadership for a larger vision regarding guidelines for healthcare.
- Set standards or endorse standards from recognised groups, e.g. US Institute of Medicine, Guidelines International Network.
- Identify and prioritise needs for SA to guide funding approaches or 'best buy'.
- Work with all stakeholders.
- Lead with specific activities such as credentialling, setting standards, providing tools, training, doing guideline writing activities and managing vested interests.
- Consider effectiveness and cost for all interventions, including devices, drugs, but also health promotion and other issues to inform best approaches for SA.

Delegates suggested that this process provides an opportunity to learn from each other and work synergistically. A small, multi-sectoral group could contribute to holistically considering the role and processes for clinical guidelines in SA. The process could include:

- A situational analysis to consider the guideline needs in SA, including competencies, relative to available skills, and potential stakeholders and contributors (the World Health Organization situational analysis conducted 10 years ago might provide a suitable approach).
- Evaluation of the various guideline unit models currently successfully in use in different countries, including consideration of the potential costs linked with the various models in light of the proposed NHL.
- Clarify what SA should be doing in this area, including potential outputs (e.g. guidelines and related products) and impact (e.g. audit assessing clinical outcomes).
- Initiate the development of a glossary of terms.
- Communicate with relevant groups, including the National Ethics Committee and National Health Research Council.

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MEMBER BENEFITS 2016

Health professionals in the prevention of drug abuse

SAMA Communications Department

In early April, the SAMA Gauteng North Branch, in association with the Pharmaceutical Society of South Africa (Pretoria Branch), held a Drug Wise workshop on the University of Pretoria Prinshof Campus.

The day-long workshop, held on Saturday 9 April, was presented by Mr David Bayever, a lecturer and researcher at the University of the Witwatersrand Faculty of Health Sciences. Mr Bayever is also the Deputy Chairperson of the Central Drug Authority, and a leading expert on drug abuse in South Africa.

In the previous edition of *SAMA Insider* we carried a short article noting the presentation and promised to provide more details about the event and Mr Bayever.

Mr Bayever began his presentation by explaining what drug addiction is, and then proceeded to highlight how health professionals fit into the picture when dealing with the problem.

Drug addiction

Drug addiction involves the compulsive seeking to use a substance, regardless of the potential negative social, psychological and physical consequences.

A big part of dealing with drug abuse is to stem the supply of drugs. However, drugs are freely available through a number of unregulated outlets (including the internet), and sound more attractive rather than dangerous.

A worrying aspect of this is that the youth can access information about these drugs, and even obtain formulations and methods (recipes) for home production.

"Unfortunately, the success of treating the underlying addictive processes is minimal; where treatment and therapy are being used, the focus must still remain on prevention," Mr Bayever noted.

He said it is important that health professionals stay abreast of the new drugs and marketing campaigns that conceal the true nature of substances. He noted that withdrawal from certain classes of drugs can be life-threatening, and dangerous, and in these cases the withdrawal must be gradual, structured and closely monitored.

"Misguided chemists constantly develop new psychoactive substances with pharmacology that mirror controlled or scheduled substances. Often the dangers

associated with these new concoctions are greater than the originator drug," he said.

He said the goal for treating substance use disorders is to reduce the patient's dependence on the drug, or drug category completely, but that this is often unachievable.

"For some, the treatment strategy is to manage the dependency so that the patient can maintain normality in their lives. This may require substituting a controlled drug for the primary drug of dependency," he said.

The problem

Recent statistics from the United Nations show that African countries account for highest levels of cannabis production in the world, roughly 25% of world supply.

Data from treatment centres surveyed indicate that:

- Alcohol is the primary substance of patients admitted in treatment centres in KwaZulu-Natal, Eastern Cape, Free State, North West, and Northern Cape
- Cannabis is the most common substance abused by patients in the treatment centres in Gauteng, Mpumalanga and Limpopo
- Western Cape's use of various drugs remains high: 34% of patients are admitted for methamphetamines/Tik, 31% for cannabis. 25% of under 20-year-olds abuse alcohol (SACENDU Report, 2014).

According to statistics from the International Narcotics Control Board, only one in 18 patients requesting treatment has access to it in South Africa. This compared with the one in three who have access to treatment in North America, and one in four in Oceania.

Mr Bayever said this statistic proves again why it is essential that health professionals have a full understanding of the problems associated with substance use disorders (SUDs).

"Health professionals have unique, comprehensive knowledge about the safe and effective use of medications, and about the dangers and side-effects of inappropriate use. By providing clear information, practitioners can prevent prescription drug abuse and prevent prescription fraud, diversion and inappropriate use of medication.

"Substance abuse is a brain disease that can, like other chronic diseases, be effectively treated if a multidisciplinary approach is adopted. This must include medically assisted treatment and psychotherapy in combination. Therefore behavioural and pharmacological treatments when delivered effectively will help patients improve their functionality and health, and reintegrate them back into mainstream society," he said.

Mr Bayever noted that drug use patterns and sectors of special concern are poly-drug use (use of two or more substances simultaneously or sequentially), injecting drug use (IDU), as well as illicit drug use and IDU within prison populations.

Concern about IDU relates to indications that the occurrence of injecting drug users living with HIV and/or hepatitis C and B is relatively widespread and rising.

Furthermore, IDU, and in particular the use of contaminated injection equipment, exposes individuals concerned to contracting HIV and hepatitis C and B infection as well as loss of life.

Combination of drug use and other infections such as HIV and HCV cause other health effects, for example: neuropsychiatric complications, anxiety, depressive disorders, immune impairment, metabolic/endocrine disorders, lipid dystrophy and hepatic failure. Provision of drug abuse treatment is often a key component to successful treatment of HIV.

Barriers to access health facilities

Mr Bayever noted that studies show that up to 60% of patients believe they are being treated in a negative way because of their drug use when they visit a health facility.

"Professionals must suspend all judgments and treat SUD patients like any other chronically ill patients," he said.

He noted that the relapsing nature of drug abuse fulfils the criteria for a chronic disease. Regardless of the particular substance, the diagnosis of a substance use disorder is based upon a pathological set of behaviours related to the use of that substance. These behaviours fall into four main categories:

- Impaired control
- Social impairment

- Risky use
- Pharmacological indicators (tolerance and withdrawal).

The problems associated with the abuse of chemical substances can occur acutely, such as respiratory arrest from heroin abuse, or after a period of time. The treatment offered will be distinctively different for each of the types of drugs abused.

For a few of these drugs, there are antidotes available to treat overdoses. For others, and in cases of poly-drug use, treatment is symptomatic and supportive.

Early intervention and recognition of the drugs, and initiation of detoxification, can make all the difference to the final outcome for the patient. The treatment of intoxication will impact on the ultimate outcome.

But, said Mr Bayever, a big part of the problem of treating abuse is that a large percentage of chronic drug users do not comply with medication regimens.

Drug abusers are malnourished; they have suboptimal antioxidant micronutrients such as selenium and zinc, and therefore have a higher risk of mortality.

"The provision of drug abuse treatment is often a key component to the successful treatment of HIV disease. Social disintegration is accelerating under adverse influences of growing poverty, civil disobedience, tribal conflicts, droughts, massive displacements of populations," according to Mr Bayever.

He further noted that modern neuroscience shows:

- drug abuse is fundamentally a form of maladaptive memory

- that the introduction of a substance or a behaviour intensifies brain reward system and circuits
- for some ($\pm 16\%$) it creates conditioned association with outside cues
- the cues acquire strong salience that overwhelms other behaviour
- a person becomes drawn to involuntary compulsive repetition of experience (immediate gratification) that results in long-term consequence and responsibility neglect.

The role of health professionals

Mr Bayever said that health professionals are well positioned to respond to the crisis of substance abuse but that they tend to isolate themselves and limit their involvement.

"We must avoid assuming preventive roles, and embrace our professional responsibility. We must move from the practice into the community," he said.

He said that in the same way other chronic, relapsing diseases, such as diabetes, asthma, or heart disease can be managed; successfully, so can drug addiction be

managed; and the health professional has a role to play.

Relapse does not signal failure, it indicates treatment should be reinstated, adjusted, or alternate treatment is needed for the individual to regain control and recover. Health professionals must listen to the patient carefully, and, importantly, patients need to be respected.

"As concerned citizens, and members of a greater community, we must recognise that the overarching purpose of drug control is first and foremost to ensure the health, well-being and security of individuals, while respecting their agency and human rights at all times.

"We must commit to treating people who use drugs with support and care, rather than punishment. We should motivate for alternatives to incarceration for sufferers of SUDs. Healthcare professionals can support and empower communities, and civil society by calling for a rebalancing of investment in drug control to ensure that the resources needed for SUD services and treatment are fully funded, including harm reduction and opioid substitution treatment, maintenance and after care," Mr Bayever concluded.

United Nations Office on Drugs and Crime, 2014: Drug use estimates for 15 - 64-year-olds in South Africa

• Cannabis 7.5%	(World 3.8%)
• Amphetamine type stimulants (ATS) 0.9%	(World 0.7%)
• Cocaine 0.4%	(World 0.4%)
• Opioids 0.3%	(World 0.7%)
• Opiates 0.3%	(World 0.4%)

About David Bayever

David Bayever is a lecturer in the Department of Pharmacy and Pharmacology, Faculty of Health Sciences at the University of the Witwatersrand. After qualifying as a pharmacist, he joined his father in practice in Benoni.

In 1980 he became aware of the overuse and misuse of prescription and over-the-counter medicines and, in particular, the abuse of benzodiazepines (tranquilisers and sleeping tablets) and narcotic drugs (pain killers).

He became an active member of the Pharmaceutical Society of South Africa (PSSA) and canvassed for pharmacists to become involved in a similar campaign to Pharmacists Against Drug Abuse (PADA) which was started in America and was supported by the then First Lady, Nancy Reagan.

At the time, he was asked by the President of the PSSA to start a similar campaign in South Africa and started the Drug Wise Campaign of which he was the national convenor until 1998.

At that stage Drug Wise had become recognised throughout the country as a resource and research centre concerned with the abuse of both licit and illicit substances. He was appointed by the Minister of Social Development as a member of the Central Drug Authority (CDA) for the first time in 1999 and remains a member to date. He is currently appointed by the Minister as the Deputy Chairperson of the CDA.

The Minister of Sport and Recreation appointed him to the Board of Directors of the South African Institute for Drug Free Sport in 2013. He also represents South Africa as the Co-Chair of the Anti-Drug Working Group of BRICS Member States, serves as an inspector for the South African Pharmacy Council and is the moderator for Foreign Student's Forensic Examinations.



Special voluntary disclosure programme: It's now or never!

Gert Viljoen, *VPROF*

The recent revelations of the Panama Papers confirm a growing trend – it's getting mighty difficult to hide money from the taxman or Reserve Bank. In the current social media and information age, embarrassing data just keep slipping out.

Aligned to this, the Organisation for Economic Cooperation and Development (OECD) has introduced a project whereby there will be an automatic exchange by participating countries of taxpayer information. This information will be supplied to the local revenue authorities and shared with other revenue authorities. Over 100 countries have signed up and this data sharing will happen by end September 2017. As most tax havens have agreed to supply information, this will make keeping undisclosed accounts a very risky venture.

This makes it more important than ever for anyone needing to regularise their tax or exchange control affairs to understand and consider the proposed new special voluntary disclosure programme.

Voluntary disclosure programme (VDP)

In 2003, the VDP was introduced. It is estimated that between R3 and R7 billion has been recovered by the authorities. A further VDP was introduced in 2010.

Although the VDP gives those who have made disclosures immunity from prosecution, no administrative penalties and much reduced understatement penalties, it has had limited success.

The main reason advanced for this was that there was no cut-off in terms of how far back SARS can go to determine a taxpayer's liability and no relief provided for interest levied.

In addition, the Reserve Bank has been levying penalties of more than 20% for participants of the VDP. This Reserve Bank penalty plus back taxes has made it unattractive for many taxpayers to enter the VDP. Thus they have either emigrated or sat on these undisclosed accounts.

The amount of funds in these offshore accounts is unknown but substantial. The recent leaking of account information at HSBC showed South Africans held R28 billion

in Swiss accounts. As this is only one bank, this represents a small percentage of actual South African offshore holdings.

Proposed new special VDP (SVDP)

The SVDP was announced by Finance Minister Pravin Gordhan in the Budget speech. It will run from 1 October 2016 to 31 March 2017.

What is said below relates to the current proposals – we will keep you informed should there be any changes.

It will **not** apply to taxpayers:

- who are being audited or about to be audited in connection with offshore assets or taxes
- who own trusts. But settlors, donors, deceased estates, or beneficiaries of foreign discretionary trusts may take part if they agree to **deem** they hold the trust's offshore assets and income
- who are in the position that the information comes to SARS in terms of an international agreement.

Is it worth going for?

The Finance Minister has made several changes to the new programme.

Levies by the Reserve Bank will be 5% if the funds are repatriated and 10% if left offshore. An additional 2% levy will be charged if local funds are used to pay the levy.

In terms of tax treatment the following will apply:

- Investment income and interest payable to SARS will only be applied after 1 March 2010.
- Only 50% of funds used to establish offshore accounts (prior to 1 March 2015) will be included in taxable income. According to SARS, this applies if the funds were not previously taxed, but there is uncertainty as to how this will work in practice. Hopefully this will be clarified when the legislation is finalised.
- There will be no understatement penalties and no criminal prosecutions.

Considering the information that will flow to revenue authorities next year combined with the concessions proposed, the SVDP looks like a good bet if you need to regularise your tax or exchange control affairs in any way.

Seek expert help as this is a complex process and you will only get the benefit of it if your submission is accurate and complete.

Valuing your business: Why do it, and how?

There are two reasons why you would value a business:

- Either you want to sell your business or you are thinking of acquiring another business
- Business owners should have an exit strategy. Valuing your business on a regular basis tells you how much value you are creating. It also indicates what needs to be done to make your business more competitive and hence more valuable.

How do you go about it?

Firstly, it should be noted that when buying and selling businesses, the actual price agreed will be based on negotiation between the two parties. Each party will have their own valuation and thus the actual value will be the price agreed.

Some points:

- The more history a business has the more credible a valuation as it can be backed up by a track record. With small-to-medium businesses (SMEs) one needs to build in additional risk. SMEs are vulnerable to market fluctuations and have high finance risk (e.g. a major customer doesn't pay or banks reduce credit)
- Circumstances can dictate the value. For example, selling to avoid insolvency will substantially decrease the valuation.

Types of valuation

- **Asset values:** Investment houses, capital intensive industries and property companies are often valued based on their assets. An investment house, for example, owns stakes in various entities and it generates its income from these investments. Thus it is valued, based on the worth of its investments.
- **Price earnings ratio:** This is the most common method and the valuation is

determined by multiplying after-tax profit by the number of years a buyer is prepared to pay for these profits. An example best illustrates this. A business has profit after tax of R1 million. The valuer considers 7 years appropriate for your business. The value is therefore R7 million.

- How do you determine the number of years? This is obtained from the stock exchange, which is considered an efficient market. Currently the market trades on just below 22 years of earnings. This number is reduced for smaller entities as they are not as marketable as JSE shares and they carry much higher risk. In today's market an SME with a good track record can expect to get between 5 - 7 years of after-tax profits.
- Are adjustments made to after-tax profit? Adjustments should be made for one-off events (e.g. the sale of a large asset) and any other items which prevent making the after-tax profit a true reflection of the business' profits.
- There are **other methods of valuation** such as discounted cash flow or entry cost (for new businesses).

Other factors

One would also need to consider other aspects when arriving at a value:

- How good is management?
- Do you have good relationships with major stakeholders?
- Is there effective governance?
- Are there some unique features in the business, for example dominant products in their markets?

These would be used to increase or decrease the number of years' earnings to apply. For example, very strong management may convince the valuer to increase the figure from 7 to 8 years, thus increasing the valuation.

Making use of valuations can be an important tool for your business.

It's time to do your COIDA return

Your Compensation for Occupational Injuries and Diseases Act (COIDA) return of earnings was due by 31 May. It is easy to register (if you haven't already done so) by email and to complete the return online. COIDA contributions are not too costly and depends on the industry you are in.

Why register and do the return?

- It is another insurance policy for your staff. If an employee gets killed or injured or contracts a work-related disease at work, for example, he or she is eligible for compensation.
- Unless you comply with the Act you cannot get a certificate of good standing.
- Finally, it is not worth exposing yourself to the risk of fines.

What happened to the discounts?

For those who remember the events of 2013 when discounts of up to 10% were offered for timeous completion and payment, these discounts are now being processed. If this applies to you, the Department of Labour will either refund the discount or deduct it from your assessment.

What if I haven't registered?

Senior officials have apparently confirmed that they are still not levying interest or penalties. You will be required to complete the current return plus the prior four years of returns.

The Department of Labour is making it relatively painless to get yourself into the COIDA system.

Small businesses: How to access finance

Surveys indicate that one of the major reasons for SMEs going out of business is cash flow issues. SMEs are the most powerful generator of jobs in the economy and thus their financial wellbeing is extremely important.

In South Africa there is no large-scale venture capital or private equity industry. Government does offer incentives but they are not well marketed and can be difficult to access. That leaves the major banks and one or two other funders.

A recent survey by the Reserve Bank found the following when looking at bank loans:

- Loans to medium-sized businesses have shown healthy growth over the past few years. These are defined as entities with annual sales in the region of R400 million. Loans to this category grew by 80% from 2008 to 2015.
- In the small business sector there has been no growth at all. This segment is defined as

loans of up to R7.5 million. The total loan book of banks only exceeded April 2008 in October 2015.

Why do small businesses find it hard to access loans from banks?

Since the global financial crisis banks have become more conservative and risk averse. In this environment, small businesses are the first to suffer.

SMEs less than 2 years old have been particularly hard hit. As they have no meaningful track record, banks are loath to lend to them unless they have good security and a good business case.

The pattern shown in the Reserve Bank report is that banks like to begin with transactional banking. They therefore open current accounts, money market accounts and see how the businesses operate. Once the banks are comfortable with the business they will then consider advancing loans.

The problem is that new businesses are cash hungry when they start and often if they get through the first 2 or more years they can come up with a creative plan.

Are there finance houses out there?

Yes there are. The one that springs to mind is Business Partners, which in 2015 increased lending from R673 million to R1 billion. This type of lending comes at a price – interest rates are higher and very often the finance house take an equity stake in the business.

So what to do?

- Be very cost conscious.
- Budgeting carefully.
- Be precise if you need to borrow money.
- Inform the funder how much money you need and what will it be used for.
- Consider when and how you can pay back the loan
- Make sure your credit record is good. If you have an adverse credit history, settle old debts. With current technology, potential funders will almost certainly unearth your history, so be upfront about it.
- Try to build up some form of security and/or establish sound relationships with stakeholders such as suppliers and debtors.
- Remember it can take several months to secure funding so take this into account.

New SAMA member benefit

Jeanette Snyman, SAMA Marketing Officer

SAMA is in the process of adding a new member benefit by negotiating discounted rates for BMW vehicles. On 5 May BMW invited members of the SAMA Marketing Department to go on a plant tour.

A group of 19 people had the privilege of driving different BMW vehicles, for e.g. the X3, X1, 740i and the 640 diesel on our way to the Rosslyn Plant.

Our tour guide, Danny, explained the duration of the tour, safety rules and regulations and we were all dressed in a white dust coat.

The Rosslyn Plant is the only BMW plant in the southern hemisphere, and although it is the smallest of all the plants worldwide, it produces 360 3-series BMWs per month to be distributed worldwide. The production is divided into three sections: the Body Shop where the body of the car is produced. This is such an amazing sight to see – massive robots put all the parts together. One robot alone is responsible for 290 bolts that are welded onto the body of the car in just 4 minutes. All of these robots are computer programmed and responsible for a specific function. The second part of the tour is the Paint Shop where the cars



A group of 19 people from various organisations met at the Autobahn dealership in Isando.

are painted according to the customer's order. The machinery that does the painting is worth ZAR550 000 000 and the cars are manufactured individually according to the customer's specifications. The last shop is the Assembly Production Line where all the other parts are inserted into the car. At the end of the production line, the engine starts for the very first time and the last quality check is done by women, who according to Danny "pay attention to detail".

Here are a few interesting facts:

- It takes 55 hours to produce one vehicle.
- 360 3-series BMW vehicles are produced per month in South Africa alone.
- 57% of the 3-series BMW vehicles are exported to the USA.
- You have a 90.5% chance of survival if you are involved in an accident in a BMW vehicle.

SAMA members will soon be able to receive an 8% discount on BMW vehicles.

Facility to improve care opened

Molly Green, Volksblad Media 24

A milestone was reached when a brand-new state-of-the-art Rand Mutual Care Facility for pensioners and beneficiaries with occupational injuries was opened. The 120-bed custodial and care facility worth R62 million brings to realisation a long-cherished dream of Rand Mutual Assurance (RMA).

Commenting on the opening of the facility, Dr Deodat Kritzinger, General Manager: Medical of RMA, said that the RMA team was proud to see its vision of an own-care facility come to fruition. He also said the facility would enable RMA to provide better long-term treatment and care for seriously injured pensioners.

"It is our hope that the new Rand Mutual Care Facility in Welkom, which provides live-in care for RMA's long-term custodial care pensioners, as well as services such as wound care, rehabilitation, prosthetics and proactive interventions for RMA beneficiaries, will serve as the ideal environment for them to grow and develop," said Kritzinger.

He expressed his satisfaction that that this centrally located facility would provide relevant specialist services and professional care, as well as presenting residents with the opportunity to learn new skills.



The Rand Mutual Care Facility in Welkom has been officially opened. From left: Dr Deodat Kritzinger (General Manager), Mildred Olifant (Minister of Labour) and Dr Vincent Maphai (Chairperson of Rand Mutual Assurance).

"We identified that many RMA pensioners, particularly those who have suffered severe injuries, were in need of quality long-term care and this dedicated facility will cater to their requirements."

Skiping over the details

Medical Protection Society

One night Mr K, a 37-year-old builder, felt a lump in his testicle. Worried, he decided to attend his general practitioner on Saturday with his wife to have it checked.

When Mr K arrived at the surgery, he was seen by Dr G, as his last patient in the emergency slot. The consultation was short, only lasting a few minutes. Dr G examined Mr K briefly and reported his finding to them as "just a little gristle that will go away with time". He did not give any particular advice.

He added that there was "nothing to worry about" and he wrote in his medical notes "testicular examination: NAD". Dr G appeared disgruntled that Mr K had used the emergency appointment for a routine check-up. Mr and Mrs K later reported that Dr G had appeared dismissive and tired throughout the brief consultation.

One year later, Mr K attended his general practitioner's surgery with a painless hard lump in his neck. Further investigations and referrals led to Mr K being diagnosed with a testicular choriocarcinoma.

Despite treatment, Mr K died 2 years after the diagnosis. A claim was made against Dr G regarding his management of Mr K. The experts agreed that earlier diagnosis would have improved Mr K's prospects and they were very critical that Dr G didn't advise on any further follow-up or investigations; the case was therefore settled for a substantial sum.



Learning points

- Unplanned appointments are inherently high risk, so writing good notes is even more important in this setting. On this occasion the records did not help resolve the factual dispute in the case. The medical notes should always reflect the clinical findings. If there was a palpable lump described as "gristle" to the patient, the clinical notes should have made a mention of it.
- Medical Protection has considerable experience of claims that have arisen from factual disputes between patients and doctors. This case emphasises the importance of making as full a note as you can, particularly if you cannot find what the patient is reporting.
- In this case the patient presented as an emergency, which would have been taken into account in assessing the honesty of his assertion that he was acutely worried.
- It has been recognised that delay in presentation is an important factor in men with tumours. Even if the clinical findings are clear, then men should be given advice, documented in the notes, to seek attention again if they have any concerns.
- Always be mindful of how human factors can affect your performance. Remember the HALT mnemonic (Hungry, Angry, Late, Tired); where possible anticipate these and take action to mitigate their impact. Where they are unexpected then be prepared to seek the opinion of your colleagues or bring patients back at the earliest opportunity to fully address their needs.
- Most patients with testicular cancer present with a painless, solid, unilateral mass in the scrotum or an enlarged testicle. However, it is worth being aware that there can, rarely, be a decrease in testicle size. Around one in five men with tumours will have pain at presentation. The SIGN guidance *Management of Adult Testicular Germ Tumours* provides advice on the diagnosis and presentation of testicular tumours. The guidelines recommend that anyone with a lump or doubtful epididymo-orchitis or orchitis not resolving within 2 - 3 weeks should be referred urgently for urological assessment.

Eastern Highveld holds successful CPD meeting

On 16 March 2016, the SAMA Eastern Highveld Branch hosted an ethics lecture at the Holiday Inn Johannesburg Airport Conference Centre. Despite its confusing title, the Hotel complex is situated just off the N12 highway in Boksburg, giving easy access from any direction for members in our area. Our branch offers these CPD lectures as a service to our members, with no levy charged.

The Chairman, Dr Jess Bouwer, thanked those members who attended; however, it was disappointing that we fell just short of our target of 50 delegates,

despite several sms notifications and notices in the SAMA weekly newsletter. This event gave those delegates who were present 6 ethics points, and all our speakers presented excellent ethics talks.

Our speakers were Dr Pheello Lethola from the South African National Blood Services who spoke on "Ethics in blood transfusion", followed by Ms Ulundi Bhertel "HPCSA, NHI and the CC – the Good the Bad and the Ugly of the healthcare sector"

As social media is so much a part of our daily lives, Marli Smit, SAMA Legal Advisor, spoke on "Healthcare professionals and

social media." This was a very informative talk and although it was aimed at doctors, the content could be applied to everyone. The watch word is CAUTION with social media. To conclude the lectures Dr Bouwer introduced Ms Jeanette Hunter, Deputy Director from the Minister of Health's office on the topic of "Primary healthcare and the role of the GP in the National Health Insurance system.

There was a lively debate after the Deputy Director's talk and many points were raised, which were carefully noted by Ms Hunter for feedback to the Minister of Health.

NHI White Paper at Goldfields branch

A White Paper Consultation with the Health Professionals of Lejweleputswa (Goldfields area) took place on Monday 18 April at the Bongani Regional Hospital in Welkom.



PROGRAMME

**FREE STATE PROVINCIAL ROADSHOWS
AND CONSULTATIVE POLICY PROCESSES
ON NHI WHITE PAPER**

VENUE : Bongani Regional Hospital, Nurses Home Hall, Welkom

DATE : 18 April 2016

TIME : 18h00 to 20h00

Program Director: Mr M Mvambi		
18h00 – 18h05	Welcome and Introductions	District Manager
18h05 – 18h10	Purpose	Mr. SC Polelo
18h10 – 18h15	Introduction of the HOD	Dr. BE Mzangwa
18h15 – 19h00	Presentation of the NHI White Paper	Dr. D Motau
19h00 – 19h30	Comments/ Points of Clarity/Suggestions	Mr. M Mvambi
19h30 – 19h50	Way Forward	Mr SC Polelo
19h50 – 20h00	Vote of Thanks and Closing	Dr. SS Matela

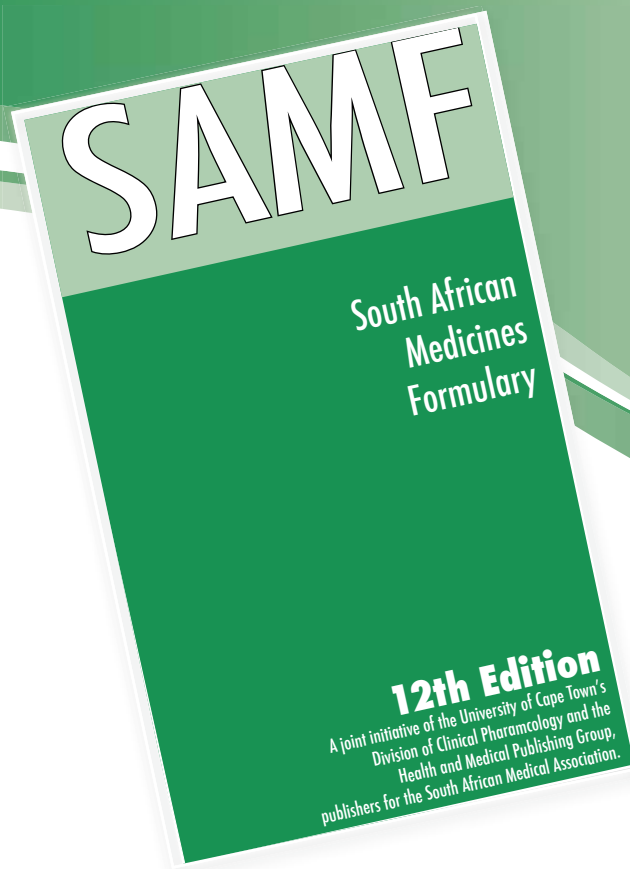


The White Paper consultation in progress.



Gauteng branch to hold male sexual health symposium

The chairperson of the Gauteng branch, Dr Kallie Spencer, is pleased to announce that on 11 June 2016 the branch will present a symposium on Male Sexual Health in association with Bayer Health. The venue is the Discovery Auditorium on 155 West Street, Sandton. Time 9h30 - 15h00. The meeting is CPD accredited and includes ethics points. Refreshments are included. RSVP Shelley: Samajhb@global.co.za by 1 June.



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