THE SOUTH AFRICAN MEDICAL ASSOCIATION SUBMISSION TO:

THE COUNCIL FOR MEDICAL SCHEMES

In respect of

Department of Health Notice 435 of 2017 and CMS Circular 39 of 2017:

Invitation to interested persons to make written presentations concerning the intended declaration of certain practices by medical schemes in selecting designated health care providers and imposing excessive co-payments on members as irregular and undesirable practices by the medical schemes in terms of Section 7 of the Financial Institutions (Protection of Funds) Act, 2001, Read with Section 61 of the Medical Schemes Act, 1998

30 June 2017

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EXECUTIVE SUMMARY

The South African Medical Association (SAMA) is extremely pleased to have this opportunity to present concerns regarding processes applied by medical schemes in selection of designated service providers (DSPs) and application of excessive co-payments on members.

We have collected multiple comments directly from our membership which faces these challenges on a daily basis and we hope that these can clarify the technical applications of scheme rules which we believe make these practices undesirable and irregular.

We have also taken note of the CMS Press release 11 of 2017 (26 June) and have restricted our submission to comments on fair practices and procedures when appointing DSPs and the rules which result in the application of excessive co-payments as requested.

There are, however, issues directly related to DSPs and co-payments which have emerged from the comments of our membership, for example manged care network arrangements, which we would also like to bring to the Council's attention.

- ***SAMA is in support of the intention to declare the following business practices irregular or undesirable:***
  a. *The selection by a medical scheme of a healthcare provider group or group of providers as DSPs without engaging in a fair, equitable, transparent, competitive and cost-effective process.*
  b. *Imposing a co-payment in terms of Regulation 8(2)(b) that exceeds the quantum of the difference between what is charged by the scheme DSPs and what is charged by a service provider who is not a DSP of the scheme*

Requests from SAMA in response to Circular 39 of 2017:

We request that the Council for Medical Scheme considers the following:

- *Network and other managed care practitioner arrangements which are set up with the same lack of a fair, equitable, transparent, competitive and cost-*

effective process as DSP arrangements should also be declared irregular and undesirable business practices

- *The Council for Medical Schemes should not approve scheme rules which seek to unfairly punish medical scheme members for the use of non-DSPs.*
- *Acts of actively punishing scheme members for using out of network or non-DSP practitioners should also be declared irregular and undesirable*

Overarching concerns relating to many of the issues submitted by SAMA members:

- *Many of the DSP appointments, network arrangement and co-payment rules which result in unfair exclusion of practitioners from DSP arrangements, and excessive co-payments for patients are actually enabled by the rules of the medical scheme concerned. These have been approved by the Council for Medical Schemes.*
- *Managed care practitioner network arrangements suffer from similar levels of non-transparency and inequity as pervade the DSP space.*
- *Network tariff arrangements also result in excessive co-payments for scheme members.*

In addition our membership has indicated the following a challenges relating to DSP and managed care arrangements:

- *Criteria for selection to DSP status are frequently opaque and exclusionary.*
- *The same situation applies to managed care determination of doctor networks, which are not only set up to serve as vehicles for PMB*
- *General practitioners in small, rural or underserved areas are excluded from DSP arrangements and networks on the basis that the volumes of patients which they see are "too low."*
- *Practitioners are excluded from "closed" DSP and network arrangements which are deemed "full" by schemes – thus even a practitioner willing to join the network or DSP arrangement is excluded.*
- *Practitioners are excluded from participation in networks or DSP arrangements on the basis of "claims histories" which are not explained nor are the criteria for qualification for networks or DSP arrangements made transparent to them.*

- *DSP practitioner or network practitioner appointment takes place by "exclusive invitation" only and willing practitioners cannot participate.*
- *Doctors who do not wish to participate as DSPs are selected as DSPs without their knowledge and are then unable to change their status.*
- *Referral requirements imposed by DSP status see practitioners being forced to refer patients to specialists other than those they would recommend in all other circumstances.*
- *Unilateral decisions are taken by schemes at the beginning of new benefit years to change DSP providers, impacting hundreds of patients who are forced to leave their existing practitioner who was a DSP the previous year and seek treatment with the new DSP.*
- *Often this results in supersession without the necessary inter-professional communication, which is in contravention of the Health Professions Council's Ethical Rules.*
- *SAMA has also received evidence of schemes continuing to insist on patients receiving treatment at public sector facilities (which are the DSP in terms of the scheme rules), despite the legal precedent rulings in this regard.*
- *SAMA also received a number of inputs regarding suspected perverse incentives operating in the chronic and other medicines formulary space at various medical schemes.*

Summary of issues regarding co-payment structures:

- *Network and DSP tariff arrangements are designed in such a way as to reward practitioners joining the network with higher than scheme rate tariffs. Non-network or non-DSP practitioners are "punished" through a variety of mechanisms.*
- *These include: lower reimbursement rates than what is paid to DSP practitioners, lower than inflation tariff increases following benefit year and letters directly to patients from schemes "advising" them to change their treating practitioner.*
- *Non-network and non-DSP practitioners are paid at the scheme rate, while DSP practitioners will be reimbursed at a higher than scheme rate, with the result that patients may face co-payments higher than the difference between the DSP tariff and the non-DSP tariff.*

INTRODUCTION

The South African Medical Association (SAMA) welcomes the Council for Medical Schemes' request to make submissions concerning the practices of selection of Designated Service Providers (DSPs) and imposition of co-payments on members.

SAMA is a professional association for public and private sector medical practitioners and is registered as an independent, non-profit company.

SAMA membership is voluntary and stands at over 16 500 in 2017. This includes general and specialist medical practitioners, practising in both public and private health sectors in the country.

The comments to follow represent the combination of a review of the proposals as outlined in Circular 39 of 2017 and DoH Notice 435 of 2017, by SAMA Knowledge Management and Research Department (KMRD) staff as well as internal stakeholder feedback from SAMA members and affiliated clinical societies and their members, and the SAMA Private Practice Department (PPD).

SAMA fully appreciates the spirit of the Medical Schemes Act's intention in allowing medical schemes and managed health companies to appoint designated services providers and undertake managed care activates as part of their management of costs of PMBs and their managed care provisions in general.

However, we do question the activities that have been brought to our attention which do not seem to be in line with the regulations in this regard.

PART 1: Problems experienced with the appointment processes for designated services providers

SAMA has taken several written comments from its membership of medical practitioners which have been collated as Appendix A. These speak to the specifics of challenges of general and specialist practitioner with particular schemes and particular arrangements.

In addition to DSP arrangements, many medical schemes also have networks of DSP general and specialist practitioners which they appoint on a contractual basis as part of managed healthcare processes. These do not necessarily pertain to the treatment of prescribed minimum benefits, although many arrangements overlap.

A. Criteria for selection of DSPs

The following practices by schemes have been highlighted as undesirable by practitioners:

1. Doctors are frequently oblivious as to the reasons why they are included or not included in a DSP arrangement. Criteria are frequently opaque, and doctors are often designated as DSPs without their knowledge.
2. Network lists are exclusionary – doctors complain that they cannot get listed as the list is "full" according to the administrator or because the list is "closed".
   - Submission from our membership indicates that these full networks result in patients no being able to access care timeously and having to wait unreasonable time periods for such services as ante-natal care.
   - In addition, doctors who become network providers have submitted that they often receive an influx of patients which they have never treated before as a result of unilateral changes in network arrangements. This is in fact supersession and should be dealt with as such, in terms of the Health Professional Council's ethical rules
   - There seems to be little justification inherent in limiting of numbers in a DSP or managed care network with qualifying criteria list as the more choice open to patients for healthcare access the better.
3. In smaller towns, the few doctors available "share the load" – where some are DSPs and others are not this results in non-voluntary use by patients of a non-

DSP practitioner over a weekend. Apparently this predicament is not recognized by medical schemes.[emphasis added]

4. Designated service providers lose their standing as a result of splits from practice partners and there is no mechanism for reinstatement.
5. Practitioners with multiple practices are a particular scheme DSP at one of their practices and not at the other, despite practicing the same way at both practices.
   - This is a clear indication that application of selection criteria is inconsistent.
6. Practitioners are acutely aware that selection criteria for networks award them for being “good” doctors, which primarily involves saving costs for the medical scheme.
7. Practitioners remain acutely aware of the Health Professions Council ethical rules in these instances:
   - ***Ethical rule 7: Fees & Commission:*** ***(3) A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under-service, over-service or over-charge patients.***
8. The fact that DSP contracts often involve inducements and contractual obligations to behave in a certain way i.e. prescribing only formulary-listed medicines, referring only to network specialists, restricting certain clinical investigations etc. poses a significant problem and ethical conundrum for doctors.
9. SAMA is in possession of a DSP contract in which the medical scheme also recommends acceptable private practitioner working hours. (This constitutes and employment contract and is also not permitted in terms of the HPCSA Ethical Rules)
10. Frequently DSP status is contingent on doctors being a member of an independent practitioner association (IPA). While IPAs may provide a mechanism for group contracting as well as peer review, there is no reason why non-IPA doctors should be excluded from medical scheme agreements as DSPs.

B. Conditions imposed by schemes to qualify as DSPs

Medical practitioners consider the following undesirable and irregular:

- In order to qualify as a DSP practitioners must agree to a number of restrictions imposed by medical schemes in signed contracts.
- They are forced only to refer to medical specialists who are contracted in to the medical scheme. These are frequently not the practitioner which a general practitioner would have preferred to refer his patient to.
- Specialist networks are limited in numbers to the extent that patients requiring referrals have to wait an unreasonable amount of time to see a network specialist, whereas care might be available with another practitioner.
- DSP practitioners also have to abide by scheme formularies and treatment protocols, with no mechanism to object and question.
- Doctors complain that the provisions of Regulations 15I and 15J of the Medical Schemes Act are not being upheld, or where they are, the process of approvals is so unreasonably long as to render the necessary treatment obsolete, as the patient has already progressed to more serious disease.
- In addition several of our members have submitted their concerns about the determination of formulary list for chronic and other diseases. Aside from the unfair co-payments which the council already aims to address, members Are concerned about the specific products listed, which seem to garner prolonged formulary listing status regardless of prices changes in competitors and utilisation in the market. There is also concern about how this relates to the so-called “housebrands” of pharmacy chains which are designated DSPs.

C. Where hospitals are DSP but Practitioners are not and vice versa

- It seems to frequently happen that a DSP specialist practitioner is appointed but practices from a non-DSP hospital.
- Because of the penalties imposed on patients and the costs of hospitalization, patients are forced to seek healthcare at a different hospital, leaving their original specialist to have to see a new specialist who may not be on the DSP list, leading to the patient having to incur co-payments and start the evaluation and treatment process all over again.

- The alternative is to face sometimes disproportionate and fixed penalty co-payments for receiving care at a non-DSP hospital.
- Appendix A provides some specifics of where this has greatly negatively disadvantaged patients and their quality and continuity of care.

D. Communication to members with regard to DSP and non-DSP practitioners

- Practitioners complain that schemes tell their members that they will be "overcharged" if they use the services of a non-DSP practitioner.
- This is misleading to patients and disparagement of a healthcare professional, often with no basis for this assertion.
- Schemes will not hesitate to disrupt provision of care to patients by practitioners and recommend a "list of preferred providers" from whom a patient must presumably choose to continue their care.

PART 2: Problems experienced with excessive co-payments as a result of tariff structures

Doctors who do not sign DSP arrangements are being "punished" by the following mechanisms:

- Lower tariffs paid to non-DSPs, which often means that a non-DSP is paid far less for rendering the same service as a DSP practitioner.
- Schemes do not pay non-DSPs directly, and instead pay claims directly to patients, which often means practitioners have to engage in debt collection and administration to recoup the reimbursed amounts.
- Medical aids apply penalty co-payments to patients seeing non-DSPs even where the non-DSP practitioner is willing to bill the same amount as the DSP tariff. SAMA is in possession of several specific examples of where this is occurring.
- In addition, the practitioners have indicated that they are forced into accepting tariffs far below what they should be charging to keep their practices sustainable because of the "take it or leave it" attitude of the medical schemes. Practitioners are fearful of having their volumes depleted and are coerced into signing contracts which are not in their or the patients' best interests.

APPENDIX A – CORRESPONDENCE DIRECTLY FROM SAMA PRACTITIONER MEMBERS

1. General practitioner, Eastern Cape

To Whom It May Concern

Re: **DSPs Undesirable Business Practices**

I am a general practitioner in a rural town.
We are five "private" doctors of which two do not deliver after-hour services.
All of us are in solo-practices and therefore there is no formal "on-call" arrangement between the
doctors. Many a time, there will be only one doctor available over a weekend.

The closed-contracts make it quite difficult.

I have recently split with my partner and started a new practice in the same town. Now Discovery
Keycare and Polmed (only two examples) are not allowing me back on their network and my old,
known patients are now being disadvantaged.

Just to take the above two medical aid as examples:
I am forced to help Keycare patients at a reduced cost (who else will help them if no one else is around?)

I have also tried to refer a patient to a specialist (on Keycare), but she had to be referred to another
colleague in town (although she prefers me as her practitioner) to refer her to a specialist. He was
not available at first and she had to go on another day.

Polmed:
Polmed's database of doctors in Cradock is so outdated that it includes a general practitioner that
has passed away FIVE YEARS ago. (Dr XXX *[name removed for confidentiality]*)
… But they cannot include me in the network "because the network is full" … ??

I do understand they are trying to minimize costs, but why exclude practitioners? Should we not
consult the Competition Tribunal? Otherwise I will suggest we rather just scrap the whole network provider concept.

Yours Truly

2. General practitioner, Setting undisclosed

I am of the opinion that only allowing referral to certain hospital and certain specialists and the use of certain generic equivalents above others in the same light as price fixing which is not allowed.

I feel there should be the freedom of choice for both the patient and the doctor and not the medical aid. The medical aid has the right to only pay a certain amount for a medicine or specialist but not to decide on the choice.

I also agree with the fact that patients should not be allowed to make appointments with specialists before consulting with their GP's. This is where the money is wasted.

3. General practitioner, Setting Undisclosed

Good morning

On DSP arrangements:

1. They violate the patients' right to be treated by the doctor of their own choice. This is a very fundamental point. Some patients have been with their doctors for years and have to change doctors because the doctor is not contracted to that particular medical aid.
2. General practitioners contracted to these medical aid are forced to refer only to specialists who are contracted to the medical aid. Most of the time these may not be the specialist the General Practitioner would have preferred for his patient. Again in this setting the patient is being deprived of the best care she would get under different circumstances.
3. DSP arrangements take away the patients' right to be admitted to the hospital of their own choice. This creates major conflict for the patient. If the doctor whom the patient is seeing does not have admission rights to the contracted hospital it means the patient has to leave the doctor of her choice and find another doctor working at the hospital chosen by the medical aid.
4. It is unacceptable that when patients decide to stay with the doctor of their own choice or to be admitted to the hospital of their own choice they get punished by having to pay unreasonable co-payments. Why does the medical aid not pay what they would have paid according to the patient's plan and the patient pays the difference which would have been communicated to her by the hospital before admission, if any?
5. In some cases patients have been told by the medical aid that if the doctor is not contracted with the medical aid they will be OVERCHARGED for the services. One wonders what overcharging actually means. Sometimes an impression is created that a doctor who is not contracted to the medical will deliver substandard treatment while the one contracted to the medical aid has been approved in terms of quality of services rendered. This is obviously misleading information for the patients as the arrangements are purely based on financial issues.
6. The majority of doctors who will sign DSP arrangements are doctors who render services to the poor communities. Doctors working in affluent communities do not

take medical aid and charge whatever they think their services are worth. The DSP arrangement does not only abuse patients but also the doctors who have made the sacrifice to service less affluent communities.

7. Doctors who have not signed DSP arrangements are punished by being paid much lower payments for the same service as compared to the doctors who have signed DSP. This is not morally right and does not assist the patient in any way.
8. The other important point to note is that doctors who have signed DSP arrangements are not necessarily happy with the amount they are being paid for the services they are rendering. The typical example is a DSP gynaecologist being paid an average of R 5 500 for delivering a pregnant patient while doctors in affluent communities are being paid R 16 000. The result is that these gynaecologists have to rely on quantity to make up for the shortfall on their expenses. The more patients the doctor has to see in an hour the poor the quality of care. So who are these DSP arrangements really benefiting?

The best thing the medical aids can do is to allow patients to make use of the doctors and hospitals of their own choice. They should pay whatever fee they can afford to pay for services rendered based on the patient's plan and the patients will vote with their feet when it comes to how much the doctor is charging. The medical aid should not have a paternalistic attitude in the way they treat patients and doctors.

Thank you

4. General Practitioner, Gauteng

Undesirable business Practices

1. Using designated DSP's causes problems for patients – they can only consult certain doctors, causing additional travel costs and time away from work
2. Certain specialists are not on the "Network list" – so the choice of specialist referrals becomes very restricted
3. Certain hospitals are not on the "Network list", so choice of hospital is restricted, on patient must travel further to go to a network hospital
4. Designated Service Providers – especially General Practitioners are placed between a rock and a hard place – accept the offered contract and get the numbers, or decline and loose potential patients
5. DSPs are offered a DSP fee which is far below the fee from the general schemes tariffs, and the doctors have to accept that?
6. Most contracts by the cheapie ("affordable") schemes are very much in favour of the scheme, then the doctor and lastly in favour of the patient

5. General practitioner, Setting undiclosed

In my case ever since Polmed became part of Medscheme I have been kicked out as one of their DSP for their clients and they have been calling and advising patients to stay away from my practice otherwise there will be huge co-payments.

I have been trying to get back to their network to become a DSP without winning and yet where I practice I have a more than 60% patients fan base.
Thanks

6. Specialist Practitioner, Umhlanga

As requested I have received a letter from BestMed requesting information regarding a problem from one of my patients.

I was surprised that in the same letter BestMed is notifying and probably suggesting this patient to use one of their DSP specialists rather than continue with my care.

7. General Practitioner, Gauteng

DSP contracts and managed healthcare failed primary care dismally and are one of the biggest hurdles in achieving outcomes based healthcare.

DSP contracts do not look at maximizing value for patients via best outcomes at the lowest cost.

DSP contracts are one sided whereby the medical practitioner is a prize taker without any input into the said contract. “You either take it or leave it” principle rules the industry.

Payment is based on whether you belong to an IPA or similar group for an enhanced fee.

If you do not belong to such a group, your fee/consultation is lower and falls in the same category as non-IPA members.

The carrot on the stick is then peer review. If you are a “good” doctor, containing costs and referrals, you will be eligible for another enhanced fee.

This peer review is how ever in some cases based on up to 12 months previous data.

You are effectively paid an enhanced fee based on your data received of previous consultations, however not all costs are incurred by you.

Specialists’ admissions as well as consultations are for your account even if you did not see or refer the patient.

Peer review models are not standardized and different medical schemes will use different data to base their analytics on. You will still be peer reviewed even if you do not belong to an IPA.

Contracts:

- One-sided
- Contracts do not include formularies, but refer you to the website
- Doctors cannot dispute the formularies

- Poor adherence to Regulation 15J and 15I
- DSP signed –up doctors are promoted on the medical schemes web, thereby cohere patients to only make use of signed-up doctors.
- The pretext that falsely alluring patients to signed-up doctors are mostly that they would not need to pay co-payments on medicine, consultations etc.
- The truth is that most of the doctors do not peruse the formularies or tertiary hospitals, but signed the contracts in fear of losing patients.
- DSP contracts are thus signed mostly on a fear-based principle of losing income and patients and not on sound economical and good practice principles.
- Managed healthcare has a poor track record of managing patient outcomes
- DSP contracts should come from the medical professional fraternity with clear patient-centered health outcomes and not from the funders.
- Transform to value-based healthcare instead of managed healthcare whereby value is determined by how healthcare is practised especially at primary healthcare level.
- Managed care mostly serves to increase the volumes of patients seen by a said doctor instead of practising preventative care with good health outcomes tailor-made for the specific patients, especially around NCD’s. It becomes a volumes game.
- Peer review is not based on clinical outcomes but rather tend to be a checklist of certain procedures done, not adding value to outcomes.

8. General Practitioner, NorthWest Province

With reference to the request for submissions on this matter, kindly find my own experience below.

In principle, DSP's operate in a manner that is designed to protect the benefits of patients and safeguard the reserves of a scheme, while most importantly extending care in a cost effective manner to a cohort of patients who may not otherwise have been able to afford the costs of other options.
In essence, a DSP network consists of a group of doctors 'in sync' with the needs of the scheme and its members.

On occasion, policies and practices of networks are ill thought out and implemented, or prejudice some providers/ doctors over others. I would like to bring such an issue forth.

I practice in Klerksdorp and am located directly opposite the SAPS headquarters in the region. Many SAPS officers consult at my rooms. Polmed medical Scheme has a 'closed' GP network policy, hence I am not included on the network. My contact with the scheme revealed that they would monitor the volume of Polmed members and care they received and 'invite' doctors to participate on their network. I asked them to check their data last year and they reported low volumes (my practice commenced in January 2016). No further review has been done and no invitation received. My REPI score with Medscheme medical aids are between 2 and 1, hence i do not believe it is a quality issue. My Polmed volumes are consistently good, hence i do no believe it is a member volume issue.

It is puzzling why a practitioner who services a number of a schemes patients and is conveniently located close to their place of employment is refused participation on the schemes network.

I will make further contact with Polmed and report back on the response i receive.

9. Gastroenterologist, Gauteng

To whom it may concern

Re DSPs and undesirable business practice.

There are many issues with DSPs the main of which are

Lack of continuity of care – I see patients with inflammatory bowel disease (Ulcerative colitis and crohns). This is a chronic relapsing and remitting disease which varies immensely from patient to patient and continuity of care is extremely important both for providing quality care as well as reducing the need for repeated investigations. It is definitely not in these patients interests to be forced to see another practitioner. If penalties are small then patients can opt to remain with their longstanding doctor but if prohibitive as has become the case this is not possible.

It is my opinion that quality of care is not considered when entering into DSP arrangements- on some of the lower plans I have seen the DSPs offered and sadly when I have been asked who I could recommend the answer is often none of them – I cannot recommend a doctor to a patient that I would not take my dog to.

This is obviously not always the case but it seems to me that price is the over-riding requirement. If a doctor has a quiet practise there is usually good reason – and they would then be very happy to do things "on the cheap" in order to get patients and increase their income.

10. Specialist ophthalmomolgist, Durban

Dear Sir
Re : Circular 39 of 2017
Medical aids persistently exclude Practioners from their DSP networks.

My experience with Medihelp clearly indicates that we are excluded as DSP's even when we try to join as a DSP.

I made enquiries to several medical aids find out what their rules are to be a DSP.
Their response was I could not apply to join , they select based on an "actuarial analysis."

[See email submitted as evidence below]

2)Medical aids are applying a co-payment even when a non DSP is willing to charge the same

amount that the DSP is charging.
It is used as a negotiating mechanism to try to bully patients, hospitals and Practioners into accepting sub inflationary increases for medical service.

In addition it is used to create situation where substandard materials and services are encouraged.

Examples of this include:

A) Momentum which on some options is applying a fixed co-payment of a certain rand value to
admit patients for treatment and/or surgery.

B) Discovery Keycare which applies a 30% cop-ayment in non DSP network hospitals.
This has been the experience of the lenmed group in their dealings with discovery.
In other words even when the non DSP is willing to charge the same as a DSP a 30% co-payment is still applied.

C) Discovery Delta option which applies ridiculous co-payments at non network facilities.
Both of the above examples of medical aid behaviour is having a massive impact on patients and their ability to access cost effective care close to their homes. Please look into this behaviour and apply the necessary sanctions to bring this to a halt.

-------- Forwarded Message --------
Subject: *PR0478261 DSP network*
Date: *Thu, 12 Jan 2017 13:04:55 +0000*
From: *Enquiries Medihelp <enquiries@medihelp.co.za>*

Reference number W201701120426 has been allocated to this enquiry.

On 1 January 2014, Medihelp introduced specialist designated service provider (DSP) networks for PMB services, to ensure that members incur the lowest possible out-of-pocket expenses when requiring these services. Medihelp selected the specialists to participate in these networks after an actuarial analysis of the billing behaviour of all specialists.
The Scheme does not enter into a formal agreement with the specialist.

Therefore there is no application forms. In addition, members are not obligated to visit a DSP specialist but may visit any non-DSP specialist should they prefer to do so.

Kind regards

11. General Practitioner, Gauteng

We are a single practitioner practice and don't keep track of exact medical aid plans and medical conditions which pose problems wrt DSP's, what we have picked up though are:

- Discovery: When a patient is registered for a PMB or chronic disease, in some instances Discovery only pay part of the consultation fee, as per their PMB tariff schedule, which is not

fully covering their standard consultation fee (R346 for 2017), stating explicitly that the patient is liable for the shortfall since the patient visited a non-DSP. Even where the patient has benefits available in his/her day-to-day, Discovery won't fund the shortfall from the latter, the patient remains liable for the balance.

[Note: SAMA recognizes that it is illegal in terms of the Medical Schemes Act to pay for PMBs from members' day-to day benefits]

- Momentum (and many other medical aids with DSP-networks):
These MA's use REPI profiling to profile their DSP's - a higher score on the profile leads to higher imbursement rates to the practice (these scores are largely based on financial parameters - how much the practice costs the MA ito chronic meds, pathology, special examinations etc). This causes an ethical dilemma in the form of conflicting interests since the doctor's only consideration should be the well being of his/her patient, not the MA's financial interest, least of all his/her own ability to obtain better fees from the MA.

12. Orthopaedic Surgeon, FreeState

Please add the following from an Orthopaedic point of view: (please note this is my personal opinion and does not necessarily reflect the opinion in the South African Orthopaedic Association):

We really have many issues about DSP's:

1. Bonitas changed DSP from Life to Mediclinic in 2017. This has resulted in a major shift of patients to "new doctors" with a 30% co-pay if they prefer to stay at the specialists that have been treating them for many years. The added problem is that patient who switch to a new specialist, as we have seen with many spinal patients, now have to go to a new Dr who does not have a long term understanding of their back problem. New Xrays and MRI scans are done, as the Life hospital radiology images are not readily accessible at Mediclinic in Bloemfontein. Then the new spinal Dr will spot something and a new operation is done, which may not have been done by their specialist with 20 years knowledge of their problem, etc. This type of unnecessary money spent exhausts the reserves and is not in the benefit of Bonitas members.

Next year they will probably chose a different hospital group, and the cycle will repeat.

2. Medihelp has a list of orthopaedic surgeons in Bloemfontein as DSP's. Half of the orthopaedic surgeons on the list have either retired, died or practice in other cities. The other half don't know that they are DSP's and preferably don't want to be DSP's but can't get their names off the list.

3. Total joint replacements: Here patients face up to a 100% co-pay (about R120 000 - R140 000) if they don't go through a Pty ltd firm ICPS with their apponinted DSP's for their joint replacement. The medical aids that are involved are Medihelp, Bonitas, AECI, Selfmed, Transmed, Fedhealth, MBMed, Nedgroup, Polmed, Sasolmed and Old Mutual. ICPS take a cut of the package payed out by the funders for managing these cases.

4. The big issue that has not been address is the huge amount of supersession that occurs when patients are forcibly moved to a DSP and often the primary Dr is not even informed about this.

13. SAMA Regional Branch Membership

DSPs UNDESIRABLE BUSINESS PRACTICES

1. Patients should not be forced to change doctors.

2. DSP associated practices are controlled by Medical Schemes – compliance – incentives (higher fees).

3. Dispensing practices have subsidised medications for ± 4 years – increase from 20% to 30% and constant increase of cost of medication, contracted company not adjusted to this increase in cost (e.g. with Discovery Key Care). Patient care might be jeopardised.

4. DSP also used to side-line some of the medical practices – forced to cooperate with Medical Schemes to "control "costs (might be detrimental to patient care).

5. DSP also effect hospitalisation - sometimes only hospital authorisation for treatment not nearest to patient's address (e.g. Bethlehem Hospital authorised, patient residing in Welkom).

6. Highly suspect that incentives from Pharmaceutical companies (especially generic companies) are given to Medical Schemes and also some of the pharmacies, although it is non-competitive.
7. Just look at formularies of Medical Schemes – query kickbacks to Medial Schemes by Pharmaceutical companies to get their products listed.

14. General Practitioner, Western Cape

I am a general practitioner and have been on the Discovery Health Network for many years. Recently it came under my attention that my patients were promised 6 additional free GP consultations after their medical savings were depleted. In the past they were allowed to visit me as their regular GP for these free consultations, but all of a sudden without their or my knowledge, they must now in 2017 visit another doctor in the area with whom they are not familiar.

I sent an email to Discovery Health to enquire about the reasons for this. See the attached letter. I got a phone call from Discovery Health informing me that from 2017 there was a closed invitation sent to certain GP's to become part of the network supplying these free consultations. The GP's receiving the invitation, were GP's who made more use of the HEALTH ID facility on the Discover Health website. This is a list of all the patients visiting a certain GP and who had given permission to their GP to look up their medical records and also apply via the website for chronic medication.

The Health ID for my practice has patients that I have not seen for more than 3-5 years. The

last three times I wanted to apply for chronic medication for patients, the names of the patients were not on the list. I believe this list does not truly reflect the patients that are presently visiting me.

The doctor that has now been appointed by Discovery Health in the area for the free consultations, is not always available. One patient was told that he is fully booked for a week. I am attaching also two statements by two patients who are clearly upset with the situation and refuse to shift to another doctor they do not know for the free visits. I think this is a way for Discovery Health to avoid commiting to their promise for the free consultations.

I hope that this situation with Discovery Health will receive futher attention.

15. General Practitioner, Western Cape

In my area within 13 Km there are only two Obstetricians on GEMS list as DSP at Melomed, Bellville. According to GEMS pregnancy plan patients should have a nuchal thickness scan by 13-14 weeks. The DSP's are so fully booked that new patients can only be seen at 20 weeks for the first visit. referral to any other Obstetrician incurs a co- payment and due to lack of knowhow causes the patients extreme anxiety financially.

As a GP I cannot cover the insurance to take responsibility for these cases. Should a congenital defect arise that could have been picked up early GEMS must surely be liable for all costs of care in future.
Conclusion: DSP's constrain services and negates evidence based medicine. It should be clear that if a DSP is not available in accordance with normal evidence based medicine referral and continued care may be undertaken by a NON DSP obstetrician!

16. Specialist Physician, Gauteng

We charge (reasonable) private tariffs as this is just fair to the service provider and all patients.

We (mostly) do not sign contracts with schemes because then the doctor (who is already overloaded with the important work of saving lives) has to abide by the rules (of how many schemes?).

If we sign the contract, ICU and other PMB consultations will only be paid at a rate fixed by the scheme and not at our rate, putting the patient in a financial dilemma – if the patient is able to pay at all. (If not, the doctor with the high cost of keeping a private practice - this also involves family time etc. not just money - is forced to give a discount for work of a very high - and not lesser - standard.)

But when we do not sign the contract, schemes will not pay more than 100% scheme tariff – so the balance is for the patient.

Whether we sign or not sign the DSP contract – the patient loses. The scheme is the only winner. Not the doctor doing all the hard work. Not the patient paying those high premiums.

(It is also rather obvious that if a scheme asks a doctor to sign their contract - the benefit will be to the scheme. Unless the doctor is willing to really drown and kill himself with work.)

17. Specialist Neurologist, Gauteng

On behalf of the admitting clinicians at XX Rehabilitation Hospital:

XXX Rehabilitation Hospital is the largest Acute Physical Rehabilitation Hospital in the country. The rehabilitation programs are outcomes based, and similar to those offered in leading international centres.
The only Lokomat machine on the continent (robotic gait training aid) is available at the hospital."

Owing to the DSP arrangements of several so-called Medical Aids, patients highly suitable and eligible for this service are denied admission.

18. Orthopaedic surgeon, Gauteng

This issue of "non-DSP" is an ongoing problem, which is encountered daily in my practice and is used by the funders as an effort to avoid payment - not least of all for PMB conditions, the latter having been billed at my usual tariff (which approximates that of the Discovery Classic rate).

As an Orthopaedic Surgeon, I have a special interest in musculoskeletal tumours and sepsis. Due to the complexity of these cases, it is convention for these patients to be treated in a suitable centre, where a multidisciplinary team would normally be utilised.

Despite referral of these patients by other Orthopaedic Specialists and Specialist Oncologists, these patients are told to find a DSP in the area, who does the same work, thus forcing patients to try to find an alternative doctor. This is normally a futile search (as the patient has often already been referred by a doctor in my area because they would prefer me to take over management!) and the patient is instructed by the medical aid to pay a co-payment to the hospital, treating doctors, or both, should they come to me for treatment.

As I am a non-DSP (for all but Discovery Classic Plan patients), the medical aid - including Discovery non-"Classic" patients - refuses to settle the account in full, despite these cases being PMB conditions - and usually referred by another specialist.

A: Infected Bone & Joint (incl. arthroplasty) Patients

1. The eradication of sepsis from an infected joint replacement is quoted as commonly costing approx. £50000 - £60000 (by the European Bone & Joint Infection Society / EBJIS, of which I am a member) = approx. R800000 - R1000000.00, each time an attempt is made to eradicate

infection and revise the joint (often requiring 2 Stages, taking much time and suffering for the patient).

2. Notwithstanding this fact, septic arthroplasty patients have been coerced by funders into trying to find a DSP i.e. they are forced to seek treatment elsewhere. Supercession notwithstanding (as these patients have essentially been re-referred by the medical scheme's medical advisor), treatment has often been sub-optimal, resulting in the patient eventually coming back to me; wasted time, wasted resources and extra suffering - all extremely detrimental to the patient. There is also a risk of a joint replacement then being impossible and the patient then left with, for example, a fused knee or, worse, an amputation.

It must be emphasised that this is despite initial appropriate referral.

Spectramed, Fedhealth, Nedbank, LA Health, Momentum, Medihelp, Bankmed, GEMS are notable examples of defaulters here.

3. Repeated requests for me to speak to a Medical Advisor or for a Medical Advisor to contact me are often refused. The funders also refuse to give the details of the medical advisors and refuse to divulge whether they have discussed the case with a specialist, not least of all an Orthopaedic surgeon. This is not only unethical but suboptimal patient care.

B: Orthopaedic Tumour Patients:

Orthopaedic Registrars are trained that prior to performing a biopsy of a tumour patient they need to either refer such a patient to a tumour centre or at least discuss the case with such a centre. In fact, it is unlikely that a surgeon would pass his specialist exam if this answer was not forthcoming! The reason for this, of course, is to avoid unnecessary suffering for the patient, which would result if incorrect or suboptimal biopsies were performed or incorrect management decisions were taken.

Actually, incorrect tumour patient management could be expected to ultimately cost the funder far more - yet they cause huge problems for the patient and the treating medical team by:-

1. refusing to authorise staging investigations which delays treatment and may make a difference to saving a limb or a life. Often, despite being registered for oncology, letters of motivation, for which the medical aid refuses to pay, histopathology reports, blood results, radiology reports etc. are all requested and then some reason found to refuse payment - usually that the patient did not make use of a DSP.

One of the recent reasons for Fedhealth refusing to pay for a cancer patient's lower-limb saving treatment (after the event, of course) was that she was not expected to live more than 5 years!

2. Providing authorisation numbers and then reneging on payment later - citing all sorts of reasons. This often goes on for years with no payment from the medical aid, not even a short payment! The last thing a patient fighting cancer needs is to be concerned about paying their medical bill. This is precisely why these cases are PMB's and need to be managed in the appropriate centres.

3. Sometimes the patients have actually died, many months and even years following appropriate treatment, and the invoice remains unpaid by the medical aid. This is disgraceful.

It has even been recommended by funders form for to make contact with the patient's estate in order to obtain payment!

4. This is particularly unfair as the operations involved are complex and time-consuming (often more than 6 hours' duration) and often require more than one assistant (specialist - e.g.: orthopaedic, vascular, GIT surgeon - and GP-grade assistants). They too are left without remuneration and may be less likely to assist next time they are asked! These are clear-cut PMB, non-DSP conditions and we have followed all ethical and legal requirements.

5. Most Medical Aids have been involved in this practise but, most recently, Fedhealth, Medihelp, Spectramed, LA Health, Bonitas, BestMed, Medscheme, GEMS, Momentum and Bankmed.

C: Orthopaedic Trauma Patients:

1. Trauma patients, referred from casualty whilst I am on call, are also subjected to non-DSP rulings. Only the first procedure may be covered as a PMB and then following a motivation, informing the medical aid that I was the Orthopaedic Surgeon on call, the procedure was an emergency and therefore the patient had no choice.

Funders advise patients that if it is not life threatening that they should be stabilized and then find a DSP to continue treatment. This includes 80 year old patients with necks of femur fractures!

2. Furthermore, any additional treatment these trauma patients require will not be covered by the funder if they continue treatment with the non-DSP, as they now have the opportunity to look for a DSP, apparently. This has been relevant in polytrauma patients who require staged treatment or patients, requiring removal of fixation approx 4 - 8 weeks later as a part of the original treatment.

Patients are then forced to seek another Orthopaedic surgeon with additional costs involved and no continuity of care and increased risk of complications.

3. Most medical aids continue to default in this regard.

The CMS should ensure that medical funders abide by an ethical code, which would result in prosecution in such instances as I have outlined above.

19. General Practitioner, location undisclosed

Re: Request for comment on undesirable DSP Business Practice

ON the 16 November 2015 the Supreme Court of Appeal ruled against Genesis Medical Scheme in the Council for medical Schemes v Genesis Medical Scheme (20518[ZACS161].

IN this regard the SCA ruled that:

A. PMBS are required to be funded in BOTH private and public hospitals as provided for.
B. The Medical Schemes Act always takes precedence over the rules of any Scheme.

Despite this judgement, Genesis continues to blatantly defy the 2015 judgement and name the State as its DSP in order for payment to be made as set out under regulation 8 of the Medical Schemes Act.

[The submitting doctor provided three examples of patients where Genesis has acted recently in defiance of the SCA ruling] – these details have been omitted for confidentiality reasons]

However the emails from the scheme are clear in addressing how they perceive this situation:

Email dated 3 March 2017 from Genesis Medical Scheme in response to queries about unpaid PMB claims states:

Your email dated 01 March 2017 refers.

Kindly be advised that Genesis Medical Scheme does not provide any kind of healthcare service or treatment. The Scheme reimburses members' claims in terms of it's Rules. Genesis offers a choice of funding model for members to decide which suits them best.

Should a member choose to be treated in a private facility, even if the condition is listed as a Prescribed Minimum Benefit (PMB), the benefits and limits as set out in its registered rules will apply.

In the event that a member's claim is proven to be related to a PMB and they request for it to be paid according to the law as provided for in section 29(1)(p) of the Medical Schemes Act as well as complying with the listed Diagnostic and Treatment Pairs (DTP) as published

in the Regulations to the Act, then the treatment must be obtained in a public/state facility.

Considering the above, the claims relating to the admission dated 29.06.2016 – 23.09.2016 have been assessed correctly, in strict accordance with the Rules of the Scheme.

Settlement of any shortfalls remains the liability of the patient.

Yours sincerely,
Genesis Medical Scheme

20. Specialist Pathologist, Gauteng

With regard to notice 435 of 2017 of the Council for Medical Schemes Act 1998, we would like to make representations as follows:

A. It is our understanding that certain Medical Schemes have unilaterally and without engaging in a fair procurement process, appointed Designated Service Providers to their schemes, without offering other service providers the same opportunity to provide services to their members. This has precluded other service providers from

participating in offering their services, on an equal basis, to patients who belong to these Schemes.

B. We have been informed that some DSP’s are remunerated at higher tariff rates, than that paid to non-designated Service Providers, as negotiated with the specific Medical Schemes. (affordability and cost effectiveness rule). Our laboratory would be willing and able to compete with the current DSP’s on an equal fee rate, were we to be entitled to do so.

C. To date, we have not been advised of any tender processes conducted by any Medical Schemes, or any other procurement processes held, and as such our patient base is artificially reduced, resulting in unfair financial implications for our laboratory and for our patients, who are unfairly discriminated against since they may wish to make use of our services and expertise, but are not permitted by their Medical Scheme to do so. (quality of care and member access to health services).

D. In addition, we have knowledge that some Medical Schemes have appointed non-medical companies, to advise on treatment modalities to be made available to their members. i.e. treatment or testing as recommended best practice internationally, is rejected by the medical scheme based on business principles, and not medical expertise, resulting in the mistreatment of the patient, or the patient having to pay

E. for these necessary tests themselves. In certain instances, these tests contra-indicate additional very costly treatment which would save the Medical Scheme on the costs of the treatment, and the patient having to suffer the side effects of the treatment.

A copy of this letter has been forwarded to the Council for Medical Schemes as well as the Specialist Private Practice Committee.

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