A time bomb of resentment is ticking among doctors who are subjected to government and third-party payers interfering with the doctor-patient relationship

Open Letter to:
The Principal Officer, your Medical Scheme
General Manager, a Medical Scheme Administrator
CEO, my Hospital / Hospital Group
Manager, Assured Insurance Company

cc: Dr Monwabisi Gantsho, Registrar & CEO Council for Medical Schemes (CMS); Dr Humphrey Zokufa, CEO, Board of Healthcare Funders (BHF); The Honourable Minister, Dr P Aaron Motsoaledi, Office of the Minister Of Health, Ms MP Matsoso, Director-General, National Department of Health; HPCSA; The Competition Commission; South African Medical Devices Industry Association (SAMED); Pharmaceutical Industry Association of South Africa (PIASA); South African Nursing Council; The Helen Suzman Foundation (HSF).

The Honourable, Dr, Sir, Madam,

We, the Specialist Physicians, Surgeons and allied disciplines in South Africa, hereby declare that we have reached the end of our tether with the meddlesome bureaucratic, unprofessional, time-consuming and costly clerical and administrative problems and the misdemeanant attitude that discredit most contacts with each and every medical scheme and / or administrator in the care of medically-aided clients in South Africa.

We formally declare a general dispute

Both Government and third-party paying institutions are engaged in a bureaucratic struggle to resist the cost-based push of medical care providers and to reduce their shares of the total cost. The central focus of third-party paying institutions is to eliminate waste, but they cannot eliminate waste without causing harm to patients.

On the supply side of the medical marketplace, institutions have great resources and considerable experience at resisting change. So, in the face of a cost-control measure initiated by one institutional buyer, the suppliers attempt to shift costs to another without changing their fundamental behaviour. Thus costs are not really controlled. The techniques do not hold down costs. Their adoption and implementation affect the quality of care patients receive.

Administrative practice costs for all medical professionals have soared since the introduction of so-called managed health care. Rampant increases have been experienced in the time, effort and costs of administrative services (motivations, chronic medicines, registration of PMBs, coding issues, billing rejections, short payments, etc.), data, billing and collection services.

Increasing attention to and compliance with the rigours of informed consent, financial agreements, the National Credit Act, Consumer Protection Act, Promotion of Access to Information Act, the envisaged Protection of Personal Information Bill, data integrity and increasing levels of medico-legal litigation and indemnity insurance costs have significantly increased the complexity of medical practice. These factors
have greatly amplified administrative- and compliance costs, far in excess of the CPIX-related increases and reimbursement that de facto have been based on the illegal RPL 2006.

Our patients are often seen as adversaries bearing heaps of administration and forms, rather than the productive health care event they should engender, where all work in harmony for the good of the client and an appropriate professional fee is tendered and paid.

The third-party payer bureaucracy exerts control over the practice of medicine in many ways, including varied opinions about what does and does not constitute cost-effective medical practice. Cost benefit analysis is a mechanical device, which totally ignores patients’ preference and physicians’ insights.

Haranguing between patient, office staff and medical scheme / administrator (usually at call centre level, refusal of access to senior or executive staff) for preauthorisation, querying of codes, medicines, devices, etc. is rife.

Hospitals must receive telephone approval from the bureaucracy before admitting a patient. The person giving or denying the approval will not have met or examined the patient. The decisions will be based on a cost-benefit analysis using statistical averages, with little or no room for the non-average, abnormally sick patient. These decisions can have life or death consequences.

Clerks in doctors’ practices, billing centres, hospitals, Schemes and their Administrators are not allowed to discuss or interpret medical matters. It is incorrect, unethical and downright dangerous for non-medical clerical staff to have to dictate or record medical matters, other than basic codes and dates and practice details. Presumptive diagnostic ICD codes and procedural codes are required by the bureaucracy before the event, but we are only legally obliged to provide coding on the patient billing statements. Attending Specialists often have to resort to and spend time explaining to obstructive, non-Specialist Scheme pawns. Some Schemes are extremely obstructive e.g. require sight of histology of breast, stomach or tumours and special investigations before they will “authorise” (sic) a procedure to remove such diseases.

Scheme clinical pathways and protocols are not available without a fight: requests for these documents are flatly refused, ignored or cost money and time; when obtained, these documents invariably are found to be flawed, inappropriate, not endorsed by representative Specialists nor specifically registered with CMS. Formularies and “Scheme” rules abound. Hospitals, Schemes, Scheme Administrators and device and pharmaceutical suppliers interact on preferential procurement arrangements, solely based on raw financials, rather than appropriate health-economic deliberations and representative Specialist input.

Many instances literally attempt to dictate how medical care will be practiced - prescription drugs formularies, drug protocols, generic substitution with cheaper drugs, even the cheapest generic, limited reimbursement for treatment deemed experimental or for “off-label” indications.

Sanctions are rarely communicated with patients and deliberations are about as far as removed from patient as is the bureaucrat.

| Seldom if ever, are any Specialist requests ultimately turned down – i.e. most of the administrative bureaucracy is a waste of time and money for all involved |

We object to the serious denigration of the status and esteem of Specialists. Specialists seem to be trampled upon and invariably have their every move questioned (often by clerks, “computers”, “Scheme rules”, nurses, administrators and lesser qualified or even retired-from-practice doctors). Increasing interference with Specialist-directed care is being experienced, including denial of payment of ancillary services e.g. anaesthetic, radiology, pathology, physiotherapy, dietetics, enterostomaltherapy and wound care.
Specialists have less and less time to attend to patients

Patients are tossed around by their Schemes. Invariably they are not clued up to be able to negotiate with Schemes and all this administration gets heaped back into our offices.

The patients think “doctors usually don’t explain things well”, “doctors don’t really care about people as much as they used to” and “doctors are too interested in making money” (Reported in Gina Kolata, “Wariness is replacing trust between healer and patient.” New York Times Feb 20, 1990).

Offering our Specialist services below cost as part of our social construct and dogged determination to be good doctors has bred a disaster. The exponential increase in administration and costs to Specialists and your companies are destroying us, wasting precious resources, consuming clinical time, reducing our patient contact to nefarious adversarial fights about payment and motivations.

This is not medicine or surgery any more, but a distasteful, wasteful, acrimonious squabble that is in a death spiral – demise of clinical medicine, collapse of autonomy, overthrow of ethics, harm to patients and ruin to private practice.

The antonym to all of this is to AGREE.

Specialists are not required to “motivate” The Specialist knows what is best!

It is high time for doctors to reassume control of the situation. Hereby the rules of the game!

Tariffs:

Health Professions Act 56 of 1974: Fees charged by registered persons [Heading substituted by s. 46 of Act 29/2007]

(1) Every person registered under this Act (the practitioner) shall, unless the circumstances render it impossible for him or her to do so, before rendering any professional services, inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he or she intends to charge for such services –

(a) When so requested by the person concerned; or
(b) When such fee exceeds that usually charged for such services, and shall in a case to which paragraph (b) relates, also inform the person concerned of the usual fee.

The muddy water of tariff setting has had an important positive offshoot: each individual practice is enabled to discuss their individual fees, charges and payment arrangements without having to mention a reference price. The patient negotiates health care at the level that they can afford. Explain and discuss these.

HPCSA:

- **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. This rule clearly states that any contract that forces a doctor to save money for a medical scheme by not acting in the best interests of their patients is unethical. Whilst a contract may allow for deviation if a doctor applies for special permission from the scheme either through pre-authorisation or upon motivation, these actions represent administrative burdens. These administrative hurdles may compel evasion and preventative action by virtue of their existence; if they induce doctors to change their minds for the sake of expediency and not in the best interest of their patients, this may be disreputable.
• Professional independence is inviolate. The HPCSA does not condone intervention from advisors; share responsibility if they intervene!

• Access to confidential health care information (by fund) requires informed consent of the patient. Blanket consent is regarded as inadequate protection by HPCSA.

Medical Schemes, Administrators and medical advisors:

• Administrators may not “blanket” administer.

• All schemes are bound by the principles of administrative justice, i.e. the right to state your case where your rights or expectations are affected and your right to get reasons in writing.

• **Prescribed Minimum Benefits (PMBs):** Savings accounts may not be used to pay for PMB investigations or treatment; this includes inpatient and outpatient care, without limits or copayments. Scheme must pay for tests performed in a *bona fide* attempt to confirm or exclude PMB.

• **Protocols and guidelines** must be developed by doctors according to scientific criteria. They may not be influenced by managers or MHC whose primary objective is cost-saving. Quality care based on best practice may not be sacrificed in the interest of cost. However, quality must be seen in the context of affordability. They must be transparent, verifiable and evidence-based. Scheme to have in place ethics and review committees; written copies, including date of last review; information on committee members must be made available on request from a service provider.

• **Formularies** should be based on best practice taking cost-effectiveness into account. Financial benefits to providers according to prescriptions based on volume or formulary medicines are not acceptable.

• **Peer-to-peer communication (doctor only) prior to denial of benefits.** The legal onus rests on the Scheme / Administrator and their medical advisors to contact the Specialist on a peer-to-peer basis if they do not agree with proposed treatment. Justifiable reasons must be presented in writing. They must supply written copies of peer-reviewed intervention policies on request. The only other option is to lodge a complaint with HPCSA or to move a civil or criminal charge in the Courts.

Schemes, their administrators, hospitals and their medical advisors are at dire risk and may be held liable for adverse consequences (e.g. interference with doctor–patient relationship, unprofessional behaviour, supersession, not met or examined the patient, questioning treatment and/or tests when not similarly qualified).

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<tr>
<th>The Specialist Private Practice Committee of SAMA in 2012 unanimously invoked a motion to decry all unilateral motivations and forms. Most Specialist groups have made similar decisions concerning formularies and protocols.</th>
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<td>o The “preauthorisation” process must be changed to “prenotification” viz. checking eligibility of membership and noting of intended procedure.</td>
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<td>o No negotiation at all unless remuneration parity between consulting and procedural rand conversion factors and tiered consultations placed – this is an undeniable principle that will not be held in abeyance any longer.</td>
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<td>o <strong>No unilateral forms</strong> will be considered in any Specialist practice, ever. All forms, if any, must be authorised by a multilateral negotiation on processes and technology to streamline, standardise and preferably automate the handling of the few queries that come back to the Specialist.</td>
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<td>o Prescriptions with ICD codes and Specialist signature should suffice for all medicine and appliances for chronic medicine benefits.</td>
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o **PMBs** must be managed based on coding provided. ICD, REF process and PMBs were supposed to have been a seamless process, but they have been wrested from their intended functionality and are abused as just another way of withholding payments.

o **Formularies and Treatment Protocols.** The Scheme, Administrator, Hospital or Supplier shall only require the Specialist to prescribe and administer medicine, prostheses, pharmaceuticals or other similar patient requirements from a pre-defined list of these items (“Formulary”) if such items have been approved by a committee (“Formulary Committee”). Similarly, the Specialist may only be bound by a medical or surgical treatment protocol if the Treatment Protocol has been approved by a representative Treatment Protocol Committee. Such Committees must include elected representative Specialists to provide input and have voting rights. These Committees shall meet regularly or as required to consider adding or removing items. All Specialists shall be entitled to make written submissions for consideration at the meetings, including recommendations for the changes to listed items or protocols. The Scheme, Administrator, Hospital or Supplier shall indemnify the Specialist from any liability caused wholly or partly as a consequence of the prescription by the Specialist of any items contained in the Formulary, unless the liability resulted from any negligence or wilful misconduct of the Specialist in prescribing such items.

o **Medical aid - preferred or designated provider.** The Specialist representative bodies shall be consulted prior to a Scheme, Administrator, Hospital or Supplier commencing negotiations in respect of, or entering into, a preferred provider agreement, designated service provider agreement or similar arrangement with any related party.

o Ring fenced issues must be publicised and negotiated up front e.g. certain drugs, devices or procedures not covered and motivation on agreed format to be provided.

o All management must take place downstream – by hospital case management (they get paid for this service) and exception management processes.

### He who asks must pay. Nothing is for free.

o It is the responsibility of the Scheme to pay for the verification process at cost. All Specialists will bill the patient according to private client - attorney policies for administrative services, viz. every call, mail, fax, letter, administrative action received or sent is billed on a line-for-line basis based on practice costs and cost per unit time.

o The same principles apply to the **Insurance Industry.** Erstwhile agreements between the Life Officers’ Association (LOA) have lapsed and are illegal. The new Association for Savings & Investment SA (ASISA) and their mighty Insurance companies persevere with imposing tariffs that are obviously too low, anti-competitive, collusive inheritances from SAMA-LOA years gone by. Acrimonious interactions frequently occur as the brokers pester busy Specialists for “urgent” reports. Most doctors now insist on payment up front before they will even start completing the forms or providing details as per PMA requests. If ASISA fails to comply, we will refuse all future requests unless made in a legal fashion as per the The Promotion of Access to Information Act.

### We have tarnished our profession and it is little wonder that our status has fallen.

The USA has made these mistakes since 1990s. Why have we not learnt and transcended this quagmire of cost-shifting and money laundering without any proven benefit to health care and health in South Africa.
The reason medical schemes have taken over the provision of healthcare in South Africa to such an extent that they are telling doctors how to practice medicine is because we sold our birth right. Economic theory dictates that he or she who controls the purse strings, controls everything and this notion is borne out by our current practical experience in healthcare. By abdicating our right to bill our patients directly for the perceived administrative convenience of “direct payment” from medical schemes, we have given medical schemes the power to control the profession, since they now have the combined bargaining power of their entire membership.

**We advise Practitioners to rescind all unilateral payment or networking agreements**

We have had enough and will now have to work direct with the clients, rescind all payment agreements and try to regain control from the Schemes and Administrators.

We are in a belligerent and frustrated mood and need urgent remedies.

**Doctor, Patient and People Power will prevail**

The Competition Commission announced that it is now formally empowered by the commencement of section 6 of the Competition Amendment Act 1 of 2009 (2009 Amendment) to launch a full market enquiry into Private Sector Healthcare pricing during 2013.

We do not believe that this will be a threat to the Healthcare Professionals as costs and tariffs have been a transparent process, as was echoed by Acting Judge Piet Ebersohn in the 2010 judgement against the DoH RPL process. We do not however believe that the same can be said of Medical Scheme Administrators who unilaterally impose fixed tariff increases and “rules” across all schemes administered by them and across all disciplines, irrespective of the specific scheme’s risk profile and affordability levels.

Legally there is no longer a RPL, nor a National Benchmark of tariffs (although the legal framework for it is still in existence and could be implemented without the requirement of an exemption from the Competition Act). In the absence of any guidance to schemes as to what tariffs to apply in 2013, Schemes must independently set their tariffs. The reality is that this process is not happening and that Administrators are setting tariffs on behalf of the Schemes they are administering. If one then compares various Scheme rates it is obvious that Schemes also do not really differ from each other and that they are jointly setting a National Benchmark Tariff. This is ample fuel for the Competition Commission.

Schemes, hospital groups, professionals and suppliers negotiate in a disjointed manner, lacking in transparency. It is common practice for suppliers, hospitals and Schemes to collude on pricing, discounts, selective formularies and many other dubious issues. Specialists are seldom allowed access to these parleys and are infrequently consulted from a clinical or governance point of view.

The Competition Tribunal will hopefully sort them out!

**New, mature and equal relationship with the funding industry**

Clearly there are problems in the marketplace. Blame is in the nature of humanity – who is at fault? - The industry seems an evil empire - avaricious, secretive, manipulative, capitalist, abusing research and charities and disease mongering; its roots in caring, healing, innovation and research long forgotten. Beyond salvation?

Commitment, duty, service and caring are our lineage. The feigned wounded indignation and the idea that somehow, because we are the academic elite, we are different—we are not. Professionalism is
neither passive nor a right, but must be actively shown. In the words of a modern day icon, Albus Dumbledore of Harry Potter fame, "You have to make a choice between what is right and what is easy."

Medicine needs to be efficient in the delivery of technological service for the cure of disease and humane in its relations with sick persons. In the best institutions these aspects of practice are combined, but it is possible to get one or the other or neither. The patient will opt for humanity and the bureaucrat for efficiency, while most doctors at least try to deliver both – constrained as they are by the need not only to give patients what they want, but also to satisfy standards imposed by their peers and to earn a salary.

The drivers of healthcare inflation are hospital costs and Schemes’ administrative expenses, not doctors and Specialists. If medical schemes interfere less in the doctor patient relationship then all our administration expenses will come down dramatically.

We welcome a cost and activities based reimbursement system that fulfils the requirements of all parties. It must be an inclusive and transparent process. Specialists are willing to work shoulder-to-shoulder on these projects, believing that administrative justice and workable, enduring coding and remuneration structures can be established in support of improved access and quality of health care in South Africa.

All of these issues are at play as NHI is rolled out. Specialist services are complex issues that have not really been aired for NHI. Nevertheless, we will assist with coordination and management from a clinical and process side.

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**We need to take a strong stand on these issues**

- Patients must take up issues with the Trustees of the Schemes (directly and/or via employer/trade union); benefits = social security and human rights (note: different from pure insurance / contractual law).

- Individual practices must report interference and misdemeanours to the appropriate regulatory authorities e.g. Council for Medical Schemes (CMS) and the HPCSA. Send copies of the letters to the Principle Officer of the particular Medical Scheme, to the patient, as well as the SAGES Secretariat.

I respectfully submit these matters. Be cognisance of our availability to assist in clarification, research, discussion, negotiation and implementation

Our rights are reserved.

Yours Truly

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