NEWS

## LETLAPE LASHES OUT AT LATE PAYERS

Many doctors are emigrating because they become financially crippled by cash flow problems from medical scheme non-payments. They also perceive that scheme administrators and brokers are taking unfairly bigger bites of the private health care pie.

SAMAChairperson Kgosi Letlape recently launched a scathing attack on the private health care industry for contributing to the bankruptcy of GPpractices. He said that late payment and non-payment by medical schemes was increasing and the salaries of GPs had remained static for many years.

He added that many cash strapped young doctors were being forced to leave the profession to become businesspeople, brokers or salespeople, while many others emigrated. This situation occurred across all racial groups.

Tony Behrman, CEO of CPC Qualicare that has hundreds of doctors on its books, reported that four of its Western Cape general practices had folded over the past 18 months because schemes did not pay out in time. In the past two months, CPC Qualicare had its highest ever default in payments, with more than 40 doctors being unable to pay. He added that around 170 of the province's GPs had emigrated in the past two years because they could make a far better living elsewhere.

Norman Mabasa, Chairperson of SAMA's GPPrivate Practice Committee, said that doctors' cash flow problems meant that they were unpopular with banks. 'We have become the bad boys because of our inability to meet our financial obligations. Medical aids pay out after 90 days or not at all.'

CEO of the Board of Healthcare Funders (BHF), Penny Thlabi, said in response that blaming medical aids was 'an oversimplification' as many GP practices were folding because doctors lacked business acumen. She said that most medical aid claims were settled within 30 days if they were submitted online. Where payouts took longer than the legal one month period, doctors should lodge complaints with the Council for Medical Schemes.

## MORE PMBS FORCE SCHEMES TO PAY UP

Prescribed minimum benefit (PMB) regulations in January 2004 will force medical schemes to provide at least the level of care provided in public hospitals.

Joanne Collinge, spokesperson for the Health Department, said schemes 'can never offer less than someone would be entitled to in a public sector hospital. They can certainly offer more, but they cannot offer less.'

The PMB concept was reintroduced in 2000 after being scrapped in 1993. The current list of PMBs has been extended by including 25 common chronic conditions to protect the elderly and chronically ill who have been hit hard by dramatic increases in their monthly medical aid premiums. Compulsory benefits include treatment for diabetes mellitus, depression, kidney disease and suicide attempts. The state will be empowered to decide whether a scheme can deny expensive treatment such as kidney dialysis. On the other hand, premature babies weighing less than 1kg will not be required to be placed on ventilators indefinitely unless a medical scheme offers it as an optional benefit.

Pat Sidley, spokesperson for the Council for Medical Schemes, reported that the Council had commissioned a UCT Centre for Actuarial Research survey using Medscheme data. The survey found that the average cost for the new compulsory package cost about R740 a month for a family of four in 2001 - the comparable public sector package would cost about R420.

A six-month pilot study is under way to iron out teething problems at 12 hospitals, namely Johannesburg, Helen Joseph, Edenvale, Groote Schuur, Tygerberg, Karl Bremer, Vredendal, Kimberley, Klerksdorp, Tshepong, Potchefstroom and Witrand.

## PUBLIC HOSPITALS PREPARE TO CASH IN

The new regulations of the Medical Schemes Act due to come into effect on 1 January 2004, are likely to prove a welcome shot in the financial arm of ailing public hospitals.

The new rulings allow for medical aid schemes to send their members to public hospitals for treatment of chronic diseases, such as asthma, cardiac failure, chronic renal disease, epilepsy, rheumatoid arthritis and schizophrenia. Hospitals are cashing in by setting up exclusive wards that rival the best that private hospitals can offer, at a fraction of the price. This is expected to stimulate competition with the private sector and keep hospital costs down.

Experts believe that the regulations will give financially embattled public hospitals a significant slice of the estimated R13 billion spent on private hospitalisation each year. Pat Sidley, spokesperson for the Council for Medical Schemes, said the new regulations aimed to draw some of the R40 billion spent on private health into the public system.

Gary Taylor, Corporate Communications Director of Medscheme, said that people with low medical cover are likely to be most affected as they would only be able to afford options which primarily use public hospitals.

Dr Saddiq Kariem, Senior Medical Superintendent at Groote Schuur, said the 15 beds in that hospital's private section had generated R2.7 million since it was set up in June 2002.

According to Superintendent Sagie Pillay, Johannesburg

Hospital has thus far made R5 million from the 52 beds in its private Folateng wing also set up last year.

## STATE MEDICAL SCHEME ON THE CARDS

Evolving plans by the government to make it compulsory for all civil servants to join a medical scheme, would nearly double the number of state employees covered by medical aid.

The proposed move would mean that 600 000 more principal members could be added to the 400 000 civil servants already covered. The government would most likely opt for a restricted scheme to increase the scheme's buying power and allow it to purchase cost-effective administrative services and high-quality, low-cost medical benefits.

Public hospitals would be accredited by such a government scheme so that medical aid patients could enjoy preferential treatment in wards separate from the free public facilities. This should hopefully increase the financial viability of those public hospitals and clamp down on spiralling private hospital costs.

Membership of the country's approximately 150 medical schemes has remained stagnant at about 7 million while members have had to endure annual premium increases of more than 10% for several years.

The creation of a government scheme would directly impact the medical schemes industry as civil servants with existing coverage would have to be withdrawn from their current schemes. Industry commentators have predicted that this could lead to further consolidation amongst open schemes through mergers and acquisitions.

## DISCOVERY PROFITS SUCKED UP IN US

Discovery Health's American subsidiary, Destiny Health, absorbed much of the group's robust earnings in the six months to December 2002. The group boosted local year operational earning by 30% to R258 million, but this translated into only 6% increase in headline earnings to R85 million after the deduction of US expenses.

Destiny Health had its best half-year ever with an 84% surge in annualised premium income, growing lives covered from 3 800 to 14 800 in 2002. It is soon to conclude an agreement with a major Fortune 500 insurance company in the US.

According to CEO Adrian Gore, the group 'took the full financial effect of Destiny's costs, which was compounded by the fact that it offered no tax relief - hence the impact on headline earnings'. He predicted that Destiny would be break even on a monthly basis from December 2003.

Discovery's local operations produced a 30% increase in operating profit from R198 to R258 million, and a 19% increase in membership.

## ERRATUM

The SAMJ apologises unreservedly for any inconvenience caused by its publishing a photograph of Advocate Jannie Kotze, Chairperson of Resolution Health in place of the CEO of the Donald Gordon Medical Centre, Dr Michael Eliastam, on page 102 of the February 2003 *SAMJ*.

## FPD AND UFS OFFER HEALTH MBA

*The first class of 25 students enrolled for the UFS/FPD MBAinclude doctors, dentists, nurses and senior management in the health care sector.*

SAMA's Foundation for Professional Development in co-operation with the University of the Free State (UFS), introduced a full-fledged MBAin health care management in June 2002. This unique course was developed following requests by health care professionals who had completed the Foundation's flagship course, the Advanced Management Programme (AMP), for a formal degree expanding their business skills.

The FPD's regular AMP course stimulated further interest in the business aspects of health care among the nearly 200 health care professionals who had completed this course since its introduction in 1998. Students believed that the Foundation was the appropriate institution to meet the peculiar needs of health care professionals in South Africa for a health care MBA.

The part-time MBAin Health Care Management can be completed over five semesters (two and a half years) with three modules per semester, and four modules during the last semester. Each module will entail two days tuition at the SAMAoffices in Pretoria.

UFS will be the certification institution and will be responsible for the academic standard of the degree while the Foundation will assume responsibility for all aspects of student administration and for presenting lectures at on-campus sessions in Pretoria.

Entrance requirements are a recognised three-year tertiary qualification or recognised prior study equivalent, proficiency in English and mathematics, computer and internet literacy, a minimum of three years' relevant management experience (e.g. in private practice). An AMP or other management course qualification would be recommended.

For more details about the modules, course material and enrolment, contact Annaline on tel: (012) 481 2034 or email: annalinem@samedical.org.

MANAGED CARE

# NEGOTIATING A MANAGED CARE CONTRACT

An integral part of managed care is the negotiation of agreements with funders such as medical schemes, insurers, managed care organisations and plans.

The review of contracts is particularly important because of the increasing number of funder insolvencies and the complexity of remuneration proposals. It is recommended that all agreements be legally, ethically and economically reviewed, the latter by a financial adviser.

Furthermore, doctors should acquaint themselves with the administrative requirements of the specific funder and should ensure that all aspects of the agreement are covered by their professional indemnity insurance.

Conflict is inherent in any relationship where the contracting parties have divergent goals. Providers want to maximise their income while maintaining clinical independence. Managed care organisations want control to utilise services, reduce expenditure, spread financial risk to providers, restrict choice and enforce clinical guidelines.

There is no ideal format for a contract. The terms are likely to vary depending on the nature of the funder and the objectives of the parties.

## Contracting principles

The following nine principles should guide the contract negotiation and promote a fair and equitable agreement. Contracts should be tested against these principles to determine their acceptability to the medical profession.

### 1.Negotiation

Every contract should be negotiated between the parties although they can be assisted by consultants, such as attorneys.

A negotiated contract ensures that contracts do not favour one party and that the agreement reached is mutually acceptable. Before entering the negotiation process, each party should identify the negotiable issues, an initial position on each issue and the extent to which the party will compromise. Parties should not rush into contracts before they have had sufficient time to study the proposals of the other party. It is also important that all parties are absolutely sure they understand the provisions of the contract. An unacceptable and inappropriate contract term should not be traded for an increase in payout.

### 2.Clarity

Contracts need not be complex or lengthy to be legally binding and enforceable. A contract should be easily navigable and clear to any reader, using commonly understood terms and avoiding legal and technical jargon.

### 3.Disclosure

The parties responsible for the payment and the delivery of the health services must be identified, and the way and form in which appropriate information is shared must be defined.

The contract should contain:

- a clear disclosure of services to be covered by benefits;
- administrative procedures;
- all the financial requirements;
- arrangements that may limit services;
- exclusions, services requiring authorisation;
- procedure for authorisation;
- referral procedures;
- additional services such as dispensing;
- treatment options;
- location of services and geographical area if applicable.

### 4.Grievance procedure

The contract should make provision for an adequate procedure for grievances to be addressed and resolved between the parties. There should be provision for the resolution of grievances formally and informally e.g. through mediation, arbitration and peer review procedures. Meetings between the parties should be encouraged to identify problems and methods that promote cost-effective, quality health care.

### 5.Remuneration

The criteria put forward relating to tariffs should not only be economic but should take into account issues such as quality, appropriateness of treatment, and professional competence. No