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IPAF: Delivering promises you can rely upon

I was recently reading my grandkids the Laura E Richards children's fable, about the boy who left his family home and went in search of the "House with the Golden Windows". When he finally got there, the sun had set and the golden windows (which were merely reflecting the setting sunlight) were gone, leaving him with nothing.....

The IPA Foundation mission is to 'promote Quality, Cost efficient, Patient centric care'.

CPC/Qualicare's is the commitment to "Accessible, Quality, Cost effective, Non-discriminatory healthcare for all".

KZNDHC: "To promote and enhance quality, cost effective, accessible health care to all citizens on the basis of sound economic principles without compromising ethical standards."

ASAIPA: "We will place the interest of the practitioners it serves, their patients and the IPA's to whom they belong, before all else"

SP Net: "To create a national network of competent, self-sufficient and cost effective IPAs and affiliated providers and to empower affiliated practitioners to provide cost effective quality healthcare and to ensure that the interest of providers is catered for"

The other IPAs making up the constituent parts of the IPA Foundation all echo similar lofty mission statements, and rightly so.

The IPAF has maintained this stance since inception in 2010 and Qualicare even longer since it was first established in the early 1990's with 10 doctors.

All of our various organisations within IPAF hold prominence in the marketplace through the integrity, commitment, reliability, academic excellence and availability of a network of superb Family doctors.

We maintain contact with you through mass email communication, newsletters, websites, and regional meetings. Some also offer traveling consultants to ensure that our members remain at the cutting edge of all new offerings from bona fide medical aids, whose contracts and offerings (e.g. of Pay 4 Performance, and other forms of Alternative Reimbursement Structures) are carefully examined, vetted for practicality, competition, HPCSA acceptability and fairness and then explained to our members and distributed by the various IPAs and IPA Foundation members in a transparent and "all willing provider" manner.

DIRECTORS:

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None of our National or Regional groups countenance fraud, unaddressed waste or deliberate abuse of the system. These actions merely drive up the end cost to Patients, Funders and Administrators.

Whilst agreeing that the certain quantum's requested to be paid back derived by the Fraud divisions of many of the funders, are often unscientific thumb sucks, and would have difficulty being accepted, unchallenged, in a court of law (and be regarded as "contra bonos mores"), the IPAF and our Regional IPAs have always espoused fairness, disavowed bully boy tactics, and insisted upon an even handed approach from both funders and providers. To place the record straight, we are totally opposed to any form of fraudulent behaviour from any quarter as well as selective use of the law to justify an argument or position by funders or providers.

In our rainbow democracy, we cannot, and will not attempt to influence freedom of choice of practitioners to associate with and join which ever grouping they wish. The same is true of funder contracts. We do however not preclude anyone from signing any contract which is appropriate for their practice needs and patient demands.

We do not recommend one group over another, nor can or would we ever, act against members or shareholders who elect to sign contracts which fly in the face of financial common sense!

We urge all of our members to keep the above in mind at all times, especially when evaluating any new IPA offerings or medical aid plans, or special offers to join new groupings.

To further set the records straight, IPAF is often accused of being "too soft" with Funders. In response The IPA Foundation and all of our sister IPAs have actively and successfully challenged recent unfair medical aid decisions, removals from low cost networks, disadvantageous contracts, predatory formations of Designated Service Providers, unfairly late settlement of accounts, unrealistic expectations and offers of remuneration for work done and a myriad of other issues which have crossed our table in the past 90 days.

Whilst we cannot right all wrongs, we maintain the pressure on the funding community to ensure the mutually high moral ground of honesty, integrity and accuracy in billing, remuneration, adjudication of and payment of claims, as well as in fraud investigation.

2 wrongs however never make a right!

Fraud and Fraudulent behaviour is to be abhorred, as are the alleged tactics of certain fraud investigators which leave much to be desired and may not be in concert with the SA Constitution and the laws of natural justice. Some of them seem to show a clash of morality as in RSA you are presumed innocent unless proven to the contrary in a court of law, and not vice versa.

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Should there ever be a need for an investigator to enter your practice without or against permission, the investigators MUST be in possession of a Section 41 (a) Warrant requested by the HPCSA and issued by a Magistrate, failing which they may not enter a practice.

Prior to presentation of this warrant from the HPCSA, they may NOT, without permission of the doctors:

1. Demand to see him/her there and then, despite the fact that the practice might be full at that time
2. Before seeing the doctor, go around chatting with staff and looking around the premises to check the dispensary and the way the practice is set up
3. Demand to see ultrasounds, if a practice has one or check the serial numbers of the machines;
4. Demand to see the doctors' HPCSA card to check if it is current and valid
5. Demand to get the names and cell number of the locums that the doctor uses
6. Demand to see files of Medscheme patients to check if the dates on which the claims are sent corresponds with the dates on their system

Without the above warrant, the doctor is fully within his rights to request that the investigator leave his premises, unassisted and with no information. Failure by the investigator to comply would constitute trespassing.

We must always be sure that the doctor has not signed away certain rights within a DSP contract which may permit this type of action by investigators. I recall a Government contract which seemed to condone this type of behaviour by the fraud investigators.

Without this, the relationship between the fraud investigators and the doctor is incidental, as his relationship is with the patient. The funder plays no part in the interaction and may not demand anything.

Turning to "Evidence gleaned", you may ask if the evidence collected by Probes (medication over or under-dispensed & sealed as evidence, video recordings etc)is admissible in court as these investigators are not certified nor are they police officials, or have credentials to back up their findings.

Consider too whether there are any attempts at "entrapment" of the doctor by the investigator, or was there an offer made on behalf of the doctor to the patient to break the law? There is a subtle, but clear difference here, and experienced investigators are NOT supposed to entrap nor are they supposed to work to "targets" or cash recouped!

Finally, let's not also forget the Court of Public Opinion as well as the concept of "pro bono publico".

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The SA public will certainly draw their own conclusions reading the reports in the press of a doctor allegedly under or over servicing, under or over dispensing, or under or over charging, sharing income with patients, keeping patients longer in hospital to get the cash backs and sharing the income with the patient, seeing patients on someone else's medical aid card etc. etc. etc.

Once an Acknowledgement of Debt (AOL) is signed by the doctor in favor of the Funder, he will need a court to reverse that, and the reason must be clarified up front!

In Closing let me highlight some of the common areas of abuse which have recently been detected by our extensive peer review advisors, and in doing so, hope that none of our readers, members of shareholders will, or have ever fallen prey to the following:

Ultrasounds: a practice did them on 106% of his patients. There are no records and no reporting, for the most part, inadequate training under maintained equipment and inadequate medical assurance protection. It should be noted that this is one of the costliest abuses done by a relative low percentage of our colleagues. One being investigated by Forensics was asked to produce his machine. This was found in a storeroom covered in dust and inoperable and yet he had charged for over 600 investigations at over R600 each!! There are a number of very competent FP Ultra sonographers out there with special interests and faultless reporting. A point of service charge without reporting is being researched.

Inappropriate antibiotic use, both diagnosis and indication is highlighted and we are doing our bit in supporting the WHO in creating an awareness of the antibiotic international crisis. This is rife and is easily picked up in the profiles clinical alert section.

Acute medication costs and scripting habits both cost of as well as number of items per script and numbers of scripts per patient.

Expensive syringes which retract their needles into the cylinder. Charging for this was initially blamed upon a software aberration until one our reviewers indicated that he used the same software and that it was a conscious choice to load the cost. The NAPPI code allows us to block this payment and this has been instituted.

Multi dose vials especially for antibiotics and long acting steroids. Many of these were charged as the whole vial instead of single doses.

Impossible in rooms procedures identified including suturing of wounds requiring up to 2 hours, Ischio-rectal abscesses and others. From this it has been decided to pressure the Funders to pay

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better for in room procedures and caring including rehydration and the caring that needs to be provided but to come down hard on tariff manipulators.

Private Family Practice is the bedrock of a future NHI. Let us preserve and strengthen it, remain focused, honest, and refuse to move to the "house with the golden windows", lest the sun set, and leave everyone broken or bankrupt.

Responsible and constructive engagement with all responsible honest and committed role-players, doctors and funders alike, is really the only sustainable way forward.

Tony Behrman
IPAF CEO

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