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With IPAF, You (and IPAF) are *the network……and you are NOT a DSP!!!*

2017 sees more and more funder organisation forming their own networks of GP's thereby turning you into a Designated Service Provider. Have you ever stopped to wonder why?

The PMB's pose a significant risk and threat to Medical aids as they represent uncapped benefits to patients and for which the funders have no recourse except to establish DSPs, and use formularies, algorithms etc.

Being a member of our constituent IPAs which comprise IPAF does NOT MAKE YOU A DSP.

IPAFs offering is to contract with willing Funders and Providers to offer peer review and profiling, which, in return for good patient outcomes, and improved Quality, introduces an enhanced consultation fee paid by the Funders to participating providers. No DSP in sight!

IPAF neither encourages nor discourages you from joining into DSP relationships with Funders, however , these have recently come in for intense scrutiny , by the CMS , Competition Commission and HPCSA, so be cautious!.

Furthermore should you sign a contract with any funder group to become a DSP, and often this is built into a network contract without making it clear to you…. (IPAF prides itself on vetting contracts on your behalf for these kind of clauses!), it is expected of you to follow all of the guidelines of the respective funder, and in terms of the MCO regulations, treatment must be wallet free with no co-payments, levies, disincentives. You will be required to follow their algorithms and formularies, protocols, referral patterns limitation of referrals, hospitalisation limitation etc. etc. etc., whether they are appropriate to your patients needs or not.

Should you elect to join a DSP, consider the following?

- Is there regular contact between the Funder, your IPA, the IPAF and your practice?
- Are Tariffs offerings by the medical aid clear, uncomplicated, unambiguous and fairly represent the cost of you running your practice?
- Are the offerings in compliance with Competitions rulings, do they observe the competition commission requirement of all willing providers, and non-collusion?
- Do the Tariffs sensibly take into account your day to day running cost, fixed overheads, cost of disposables and medication as well as your professional expertise and medical defence?

What about Exciting New Offerings to bring in large numbers of previously uninsured patients to your rooms. Some are even using strap lines like:

- ***"guaranteed entry into NHI projects in the future " ,***
- ***"adequate payment" , when describing their fee offerings,***
- ***Bulk payments which include Consultations, Medication , and procedures all in one***
- ***threaten to limit their offering to the first "X" number of practitioners who apply , thereby creating artificial demand and panic in the hearts of Family Practitioners, whilst at the same time breaking the rule of all willing providers***
- ***not clearly highlighting what quality means nor patients interests.***

Some groupings tend to want to negotiate directly with doctors, use veiled threats that if you fail to contract with them, the network will be closed, and you will be too late, or your patients will be moved elsewhere.

All this is to create an artificial demand for unwitting providers to join up quickly.

The argument that they bring more "feet through your door" needs to be weighed up against the fact that their patients invariably displace other paying patients from your waiting rooms, take up your consultation time with forms, preauthorisation, and red tape and in general make practice inconvenient and unrewarding.

Ideally, no IPAF - linked doctor need worry as IPAF IS THE LARGEST VOLUNTARY GENERAL PRACTICE NETWORK IN THE COUNTRY. ANY NEW OFFERING WORTH ITS SALT, WILL AND DOES APPROACH IPAF, AND WE WILL ALWAYS COOPERATE WITH PLEASURE , AS WE REPRESENT THE MOST COMPREHENSIVE, COMPLIANT AND VIABLE NETWORK OF GENERAL PRACTITIONER DOCTORS, OPEN TO ALL WILLING DOCTORS, EMBRACE COMPETITION AND ARE IN FULL COMPLIANCE WITH COMPETITION REQUIREMENTS

IPAF IS ALSO COMMITTED TO NETWORK MANAGEMENT, PEER REVIEW, PROFILNG, AND QUALITY CONTROL. IT ACTS IN THE INTERESTS OF ALL PRACTITIONERS AS WELL AS PATIENTS.IT IS TOTALLY OPPOSED TO FRAUD, WASTE AND ABUSE.

Abuse of Practitioners by funders, and any new entrants into the funder market with unrealistic expectations of practitioners and non-viable offerings are also however unacceptable, unless the fine print is made clear to the doctors up front!

Currently IPAF has 2 new Funder clients wanting to establish further network potential for all willing providers, via the IPAF voluntary, free membership. Details should follow within the next 3 months for 2018 and will bring a further 65000 insured lives into your rooms.

In addition to the above, IPAF is aware of large numbers of employed but uninsured potential patients just waiting to come into a "system "of sorts as a result, we have actively pioneered the Pryor voucher system (see our website). In this system uninsured employed patients can obtain prepaid vouchers paid for via their employees thereby bringing the employed but uninsured patients to your practices without the encumbrances of PMB legislation.

We however caution you in getting involved with any organisation which promises new patients but itself depends on how many doctors join the new network, for that organisation to become viable and before they can deliver on their promises!

IPAF will never limit our network to a set number of doctors as IPAF will not countenance the creation of an artificial demand. To us, it is a warning light. There is NEVER any rush to join a new network.

Turning to NHI, the White paper which came out recently is still unclear; however our impression is that Family Practitioners will indeed be integral to the delivery of PHC services. Joining any network, however big or small, will NOT AUTOMATICALLY put you in line for a contract with NHI(when contracts eventually emerge).

Your practice will be assessed by the Office of Health Standards Compliance, and you will be required to meet minimum standards, which are not yet decided upon. Yes, the Ideal Clinic (The Phakisa Project) has been workshopped by the DOH, and the IPAF was integral in the design of this , but the ideal Family Practitioners rooms HAVE NOT BEEN DOCUMENTED YET!

In advance of this step however, Prof Chetty (Chairman of IPAF) devised a 40 point checklist for practitioners to use in a self-accreditation exercise, to align their practices with best practice principles. Over 3000 doctors have completed this self- evaluation and we encourage all doctors to complete and send this evaluation form in to IPAF. It is found on our website.

IPAF , some years ago concluded a loyalty program with IEMAS, and members are free to join into this loyalty program, which also assists with financing, motors car purchases , and a large assortment of special offers. Loyalty programs are however not what brings healthcare to the masses.

Successful healthcare depends upon Family Practitioners being correctly remunerated for their services, and whilst IPAF does not ever bargain for tariffs, we have to repeatedly bring to your attention the runaway costs of running a general practice, and the fact that any future capitated offering MUST take into account real practice running costs.

Bundled payments, which bulk together the consultation fee, medication and procedures need to be carefully analysed for viability, as well as for the year in which they apply. In the past various offering have come to the table mid-year, with a price for the consultation etc., but have only been effective from the following year, which automatically discounts your income by the rate of inflation for the New Year!

Low cost patients **are not low illness patients**, and instead of being paid less for treating previously uninsured patients, there is a strong argument for paying the provider a higher fee, as these patients have often never seen a doctor and require intensive workups etc.

Being bound by protocols, formularies, and policies and potentially complicated referral processes, as well as limitations of cover and of hospitalisation, can result in what seems like a viable offer of enhanced patient numbers, turning into a time consuming nightmare as has happened in the British NHS at PHC level.

The cost of switching your account costs rarely take into account the fact that you are seeing low income , low remuneration patients, and these costs too, eat into your ability to remain viable when seeing previously uninsured patients at a lower price.

Our final word, is that we all embrace plans to service previously uninsured patients, and will go the extra mile to participate in every offering, by providing collegial, non-binding, informed, mature advice to our members , who are always free to choose and make up their own minds, having carefully considered the advantages and disadvantages to their practice and their patients.

We however hope that Big Business does not see the low cost market as a place for them to make mega profits, on the backs of unwitting previously uninsured patients, and overzealous Family Practitioners who have not carefully weighed up all of the facts

Be careful before signing any new offers, think them through, put them to the test, and always feel free to approach IPAF for advice.

Tony Behrman and the IPAF Executive team