Rampantly profitable private hospital monopolies and top-heavy medical aid schemes, changed patient behaviour and insultingly low consultation fees are some of the prime causes of GPs ongoing ‘flat line’ earning capacity.

These were the major themes to emerge from a wide-ranging survey of key stakeholders, done for CME, aimed at probing the stagnant earning capacity of GPs and the increased drift of patients to specialist physicians.

Crunch the numbers of currently registered GPs in private practice to medical aid members and you get a pool of 1 166 ‘covered’ patients per GP, a seemingly workable complement to cash-paying patients.

Yet, a glance at medical aid payouts over the past decade shows GPs’ virtually ‘flat lining’ at about R2 billion per annum compared with specialists’ payouts rising from R2.4 billion to around R6 billion per annum. Over the same period, payouts to private hospitals rocketed from R3 billion to more than R10 billion per annum.

In spite of the recent swathe of patient-centred legislation aimed at increasing transparency but creating financial hardship for GPs, murky rebates on consumables in private hospital networks remain firmly entrenched, ramping up healthcare inflation. Private hospital fees soared by 15.5% last year alone, a further spike that Board of Healthcare Funders (BHF) Corporate Communications chief, Heidi Kruger, describes as ‘completely unsustainable’.

Describing the consumables rebate system as ‘unacceptable’, Kruger said that even lumping together the ageing membership of medical schemes, the burden of disease and cost of new technology, the latest hospital fee increase could not be justified. ‘We need to move the balance of power away from private hospitals,’ she said, adding that if every hospital negotiated with every medical scheme, ‘we’d see way better prices and real competition’, instead of the current monopolistic purchasing power.

The BHF did not begrudge profit making in a free market but far greater transparency was needed. In real terms GPs were getting a diminishing slice of available funds as strict medical aid limitations, shareholder profits and private hospital giants gobbled up the finite health care cake.

Kruger described a sustainable business model as one in which GPs became gatekeepers or preferred providers, getting a lump sum ‘up front’ with which they managed patients ‘right down to hospital level’. By thus saving on downstream costs, more benefits became available. This ‘GP gatekeeper model’ was backed by Professor Jan van der Merwe, chief medical consultant to the Council for Medical Schemes (CMS), who singled out patient choice as a major issue.

However Dr Johann van Zyl, head of the South African Medical Association’s (SAMA’s) Private Practice Unit, labelled capitation ‘yet another cop out’ by medical schemes. They used it to duck financial risk and pass it on to doctors.

‘We need to address the benefit structures and costs such as administration and hospitals,’ he stressed. Medical aid schemes needed to ‘stop pointing fingers and come to the party’.
By limiting ‘out of hospital’ risks, schemes had forced a move of patients away from GPs to specialists working in hospitals.

Van der Merwe said that besides the USA, South Africa was the only country where private hospitals were 100% ‘profit-making’ organisations.

Van Zyl noted that GPs and specialists together received less than 30 cents out of every health care Rand. ‘We need to look at the 70% as well,’ he added, pointing to the latest CMS health spend data.

In the past, schemes had limited day-to-day benefits, neatly passing the financial risk on to members/patients and now that this was no longer possible, they wanted to pass the risk to doctors. ‘Clearly, a more innovative and comprehensive solution needs to be found,’ Van Zyl added.

Professor Len Becker, immediate past chairperson of the Medical and Dental Professions Board (MDPB), said the practice of patients directly consulting specialists came after a rule change by the former South African Medical and Dental Council in the 1970s. This did away with the GP referral rule that still pertains in the UK.

South African patients had soon realised that they could cut out what many saw as ‘the middle man’. They began directly consulting gynaecologists for Pap smears, paediatricians for their children’s minor ailments and psychiatrists or neurologists for general malaise or persistent headache.

Becker backed the argument for GPs as ‘gatekeepers’ to contain costs. He described the unregulated private health care sector as having burgeoned out of control, with medical aid schemes squeezing ‘easy targets’ such as GPs and dentists. The schemes created limitations that influenced practice behaviour and forced many into side-room procedures and drug dispensing to make ends meet.

‘The problem is not between GPs and specialists, it’s the major expenditure of medical schemes, medicines and administration. Brokers add to it all, meaning less for GPs and specialists,’ he said.

Becker said legislative intervention was needed to force schemes to carry their own administration costs in addition to guaranteeing minimum benefits. Private hospitals needed urgent ‘containing’. ‘The medical scheme industry has been left to its own devices for too long, they’re now profit-making organisations and no longer there for the primary benefit of members.’

The original reason for their existence had been forgotten. Becker said the Department of Health needed to change its attitude and partner with doctors to address systemic problems instead of treating them as an ‘enemy of the state’.

Dr Maurice Goodman, head of clinical communication and marketing at Discovery Health, which recently announced a R53 extra payout per GP consult from January next year, said today’s GPs immediately referred if there was any complexity. ‘He simply cannot afford to spend 30 or 40 minutes with each patient, so we want to incentivise him to spend more quality time with them,’ he said.

Dr Brian Ruff, Discovery’s head of clinical risk management, said the time had come to increase remuneration to the doctor so that ‘he has the time to do the right things properly’.

Constantia GP, Murray Solomon, who believes 30 patients a day are needed to make ends meet and still give a decent service, said he would ‘believe this when I see it — though it would be marvellous’. Solomon saw no way of countering the patient move to specialists, apart from offering as good a service as possible at the most effective cost.

A GP would charge R140 for a Pap smear consult whereas a gynaecologist would charge closer to R440, ‘yet people still go’. ‘In my area I do two or three Pap smears a month when it should be that many per day!’ It was the same with paediatricians who were no longer available for a sick child with pneumonia or meningitis ‘because they’re earning money doing our job’.

GPs were being forced to ‘pump out the numbers (of patients) to make ends meet but examples of up to 80 per day in the lower-income areas meant a low quality of service.

Solomon said he saw his last patient around 19h00, then spent 2 hours calling patients to discuss results, filling out chronic medication forms, discussing medication and answering queries.

Another suburban GP, Pradip Patel, also the Western Cape treasurer of the South African Academy of Private Practice, said GPs needed to make their voices heard when specialists ‘poached’ patients. ‘Most will tell you they’re forced to by their patients who allegedly tell them they don’t have a GP,’ he added.

When confronted most decent specialists pleaded ignorance and seldom repeated the practice. ‘The ones who are battling and not providing a good service, those are the ones you usually find are poaching our patients.’

New specialists seldom saw patients without calling the GP, ‘but give them a year or two and some will see without referral notes — and they’ll do a 6-monthly follow-up and conveniently forget to send you a note’. While this was ‘not a huge percentage’, Patel said he simply stopped referring patients to them.
The new drug pricing legislation had dropped his dispensing turnover by up to 45% — the amount that used to subsidise his meagre consultation income. He had to increase his consultation rate from September and now charged for ‘anything extra; blood cholesterol, ECG, lung function test, nebulisation — whereas before I would include this’.

Patel said that in his partnership, if he dispensed R50 000 worth of drugs per month, he made just R8 000 net — if he collected every cent from medical aids and had no bad debts. ‘It just doesn’t make sense to keep that amount of stock on my shelf when I still have to package and label it, it takes up vital time,’ he said.

Dr Norman Mabasa, Chairman of the General Practitioners Society and the National Convention of Dispensing Doctors, said the 16% maximum dispensing fee made it unaffordable to stock any drugs costing above R100.

‘It’s a paradox when you talk of access and then look at diabetes, hypertension, HIV/AIDS and cancer drugs — why stock a drug on which you make no mark-up or around three per cent?’ he asked. He described Patel’s estimated loss as conservative and claimed the legislation meant up to 70% loss of dispensing income for doctors licensed to do so. Pitting the profession against itself defeated the logic and strength of doctors’ arguments.

‘The pivotal factors are the way health is funded and the laws are made. If doctors fight one another, we start assessing the punches thrown and stop assessing the reason we’re fighting at all.’ It was time logic and reason were used to make the public aware of the value of their GP. ‘Patients can’t be blamed for not using GPs enough; after all, they have no means of using the GP adequately if everyone is discouraging them from doing so!’

It was time overloaded state health institutions worked in partnership with GPs instead of relying solely on clinics or duplicating the GP’s work.

Franco Colin, one of South Africa’s 160 remaining practising psychiatrists, warned against using BHF or CMS data for comparing specialist with GP payouts. ‘They just lump all their mental health benefit payout to psychiatry but there are lots of other people with their paws in the till — it’s simply impossible for us to generate the amounts of money attributed to us!’

Colin, a member of SAMA’s specialist private practice committee (SPPC) and an exco member of the SA Society of Psychiatrists, said his biggest criticism of the GP referral system was that by the time patients were ill and had failed to respond to GP treatment, they had exhausted all their medical aid benefits.

At least 60% of referrals in his own practice were based on word of mouth. ‘If I had to rely on GP referrals I would die of starvation!’ he quipped. Colin said it was ‘absolutely illogical to put a gate-keeping clause in to protect the GP’s share of the mental health slice’.

High-tech disciplines had skewed the specialist payout portion while data lacked the detail for a breakdown of consultations to procedures. ‘I think if you compared consultations only (GP to specialist), you’d probably find the payout less to specialists,’ he said. Colin said even his fellow SPPC members were highly critical of the hospital payouts, adding that ‘they’re taking all the cream off the top and loading the disposables’.

However, gastroenterologist Chris Zaidy, who only sees referred patients, described private hospital disposables as ‘here to stay’. ‘Nobody wants the responsibility of cross infections, even if things are potentially re-usable,’ he said. Zaidy however described the rebates on disposables as ‘a minefield that doctors seldom get an insight into’. ‘Without doubt there are massive negotiations going on all the time and they’re more than murky; they’re deliberately hidden so the competition doesn’t know what’s being offered.’ He said private hospitals were reluctant to let specialists use products on which they did not get a rebate.

The BHF’s Heidi Kruger said that since the Competitions Commission had fined the Hospitals Association of South Africa, SAMA and the BHF for ‘price fixing’, it had freed the BHF to re-evaluate the ‘real input costs to a consultation or procedure’. ‘It’s fantastic having the tariff taken away from us and given to the CMS because now we can do more valuable things like help schemes design their benefits.’

The BHF was currently seeking an academic institution to help it research benefit design and create price bands based on the real input costs to a procedure or examination.

Doctors’ education, experience, specialty and overheads based on geographical locality would all be properly assessed so the BHF could fulfil its mandate of broadening access to health care for the family of the average working person.

Chris Bateman