EDITORIAL : VAN DIE REDAKSIE

NEGOTIATIONS WITH MEDICAL AID SOCIETIES AND INSURANCE COMPANIES

The Medical Association has recently passed through an extremely difficult period in its negotiations with the insurance companies which undertake medical insurance. Much criticism has been levelled at the actions of the Association — fortunately it was almost always criticism of a more or less positive nature. The representatives of the Association who had the difficult task of carrying out the negotiations used this constructive criticism as a guide to the feelings of members concerning this problem. Therefore, members can rest assured that their representatives in these negotiations acted at all times in the interests both of the doctors and of the patients who are entrusted to their care.

To gain a proper perspective of the whole problem, it is necessary to go back a few years to the beginnings of the medical aid society movement in this country. With the rise in the cost of living many people in the lower income groups found it difficult to meet their doctors' bills. Medical aid societies were formed as a solution to this problem. These societies had to comply with certain requirements before recognition by the Association, and they had to agree to pay doctors direct and in full — in turn, they were allowed a preferential tariff of fees. This agreement was reached after prolonged negotiations. Thus the medical profession, through the Association, obtained something tangible — their accounts were paid direct and in full and the problem of bad debts was minimized for many doctors. They were also able to treat many patients in their surgeries, whom they would previously have had to treat at hospitals or clinics. On the other hand, doctors performed a valuable service as part of their commitments under the medical aid scheme — they provided private attention, at medical aid tariff rates, for many patients who could not otherwise have afforded this private attention. In this way the agreement with the medical aid societies was an important and constructive step forward in the patient-doctor relationship in South Africa.

This system worked extremely well for all concerned for many years. Meanwhile, the cost of living, and especially the cost of medical services and medicine, rose higher and higher. At this stage the insurance companies entered the field of pre-paid medical care.

At first the two large insurance companies which undertook the provision of this service, decided on their own to operate on a tariff of fees which was higher than that of the preferential tariff, *viz.* the preferential tariff plus 25 and 33⅓ per cent. respectively. The premiums charged were obviously too low to cover this tariff, and eventually both insurance companies began to pay their members' accounts on the basis of the preferential tariff which had been agreed upon between the Medical Association and the medical aid societies, although there was no official recognition of these insurance companies by the Association. Furthermore, their insured members did not all fulfil the conditions laid down for medical aid society members. In other words, the insurance companies fixed their tariffs at medical aid rates even for those persons in the higher income groups who could well afford private fees.

This principle of payment was naturally condemned most strongly by the Medical Association. Matters were made worse when one of the insurance companies began to issue 'coded' cheques on behalf of its members on the basis of the preferential tariff of fees, and expected doctors to accept these cheques 'in full settlement' of their accounts. This state of affairs was quite unacceptable and caused great concern and dissatisfaction among members of the Association.

Now began a long series of difficult negotiations. For the Association the position was fraught with dilemmas, since its members were in many ways divided in their attitude to the problem. For instance, some members accepted the 'coded' cheques, while others returned them to the insurance company as a matter of principle.

It was difficult, if not impossible, for the Medical Association to find a basis for negotiation with the insurance companies which would be acceptable to them and which would satisfy *all* the members of the Association at the same time. The Association therefore followed the only path which was possible in this difficult period — its representatives continued to negotiate as far as they were able, trying not to do anything which would bring the dignity of the Association and the profession into disrepute.

At its recent meeting in Vereeniging, the Federal Council officially recognized as medical aid societies a large number of groups administered by the two insurance companies. It must be remembered that all these groups satisfied the criteria for this recognition, in the same way as the older long-approved medical aid societies did. As a basis for further negotiations, it appeared that the insurance companies preferred an income ceiling for their members below which the preferential tariff would operate. The existing medical aid societies, on the other hand, preferred to continue to operate, as they have always done, on an average income figure for their members.

The Association, through the Executive Committee of Federal Council, decided to accept a ceiling of £2,300 as a basis for negotiation. The Association is aware that many members do not agree with this figure, but some position had to be reached where negotiations could be conducted. The insurance companies had suggested a still higher figure, the Association a lower one. When this point was reached, the negotiations with the South African Mutual Medical Aid Society broke down completely. One of the main reasons for this break was that this insurance company would not agree to withdraw the 'coded' cheques.

To sum up, the position at the moment is as follows:

1. The approved medical aid societies, which function on their own and are not underwritten by the insurance companies, remain as they were and are still recognized as in the past. Payments for their members are made

according to the preferential tariff of fees. A list of these societies was published on page 1062 of the issue of the *Journal* for 10 December 1960.

2. A large number of groups which comply in all respects with the requirements for recognition as medical aid societies, but which are administered by SANSOM, were recognized at the last meeting of Federal Council. A list of these groups was published as a supplement to the *Journal* of 26 November 1960. Since these groups operate as medical aid societies, doctors will be paid for their services to members of these groups direct and in full by SANSOM at the preferential tariff of fees.

3. The level of £2,300 has been accepted in principle as a basis for recognition of other groups which are administered by SANSOM.

4. No recognition is given to *any* group insured by the South African Mutual Medical Aid Society. Those groups administered by this company, which had been approved by Federal Council at its meeting in October 1960 as fulfilling the requirements for medical aid societies (published on page 1064 of the *Journal* for 10 December 1960) also fall away as recognized groups. We have briefly given the reasons for this withdrawal of recognition from all persons insured by the South African Mutual Medical Aid Society; they were set out as well in the Official Announcement and the column 'From the Secretary's Desk' on pages 35 and 36 of the issue of the *Journal* for 14 January 1961.

5. The Medical Services Plan, which is sponsored by the Association, is at present in operation on the Witwatersrand as a pilot scheme.

It would facilitate matters for the negotiating committee if members would not make personal unilateral arrangements with the insurance companies or their agents. They should rather bring their difficulties to the attention of the Head Office of the Association, or discuss them at meetings of Branches.

Having outlined the present position, we wish to make an urgent plea to all members of the Medical Association to support the Association in this difficult matter. There may still be uncertainty for some time in the field of medical insurance, but progress, in the interests of our members, will continue. Only if we all stand together can we maintain the integrity and dignity of the profession in the face of the demands of other organizations. Furthermore, it is only by standing together that we will be able to ensure that the interests both of our patients and of ourselves are safeguarded, and that no inroads are made into our relationship with our patients or the high standing and honour of our profession.

ONDERHANDELINGE INSAKE MEDIESE HULPVERENIGINGS EN VERSEKERINGSMAATSKAPPYE

Die Mediese Vereniging het 'n moeilike tydperk van onderhandeling met die versekeringsmaatskappye agter die rug. Daar was baie kritiek op die optrede van die Vereniging — gelukkig was dit egter altyd van 'n min of meer positiewe aard. Die verteenwoordigers van die Vereniging wat met die moeilike taak van onderhandeling belas was, het die konstruktiewe kritiek wat daar was gebruik om vir hulle as leidraad te dien; daarom kan die lede van die Vereniging verseker wees daarvan dat die optrede van diegene wat namens die Vereniging onderhandel het, in die belang van die lede van die Mediese Vereniging is, sowel as in die belang van die pasiënte wat aan hulle sorg toevertrou is.

Om 'n perspektief op die saak te kry, sal dit goed wees om effens terug te kyk. Om mee te begin, het daar 'n aantal jare gelede die stelsel van mediese hulpverenigings ontstaan. Aangesien die lewenskoste só gestyg het dat baie persone in die laere inkomstegroepe dit moeilik gevind het om hul doktersrekeninge te betaal, is besluit om dié persone tegemoet te kom. Dit het dan gelei tot die stigting van die nou reeds bekende mediese hulpverenigings. Hierdie verenigings moes almal aan sekere vereistes voldoen en hulle moes die rekeninge van dokters direk betaal — in ruil waarvoor 'n voorkeurtarief aan hulle toegestaan is. Die dokters het dus iets tasbaars uit die transaksie gekry — hulle rekeninge is direk betaal en dit het die probleem van slegte skulde vir baie dokters verlig. Ook kon hulle nou 'n groot deel van die pasiënte teen betaling behandel, wat hulle anders tog maar vry sou moes behandel in hospitale en klinieke. Aan die ander kant het die dokters egter ook iets gegee. Deur die voorkeurtarief toe te staan, het hulle die dienste wat hulle as private geneeshere kan lewer, na 'n groter groep mense uitgebrei teen relatiewe verminderde besoldiging. Alhoewel die dokters dus voordeel uit die ooreenkoms getrek het, het hulle ook 'n vergrote *diens* gelewer. Dit is die basis van die ooreenkoms met die hulpverenigings. Hierdie ooreenkoms, insluitende natuurlik die vasstelling van die voorkeurtarief, het eers na langdurige onderhandeling tot stand gekom.

Hierdie stelsel het oor jare redelik goed beantwoord. Daarna het die toestand verander deurdat die groot versekeringsmaatskappye ook toegetree het tot die veld van mediese versekering.

Aan die begin het die twee groot versekeringsmaatskappye onderneem om meer uit te betaal as die voorkeurtarief, naamlik, voorkeurtarief plus 25 en 33⅓% respektiewelik. Die premies het egter te laag geblyk te wees, en altwee maatskappye het begin om op die basis van die voorkeurtarief uit te betaal, sonder egter dat die groepe van hul versekerde lede aan die vereistes van die hulpverenigings voldoen het. Met ander woorde, die maatskappye het uitbetaal teen die voorkeurtarief ook vir persone wat genoeg verdien het om as private pasiënte te geld.

Hierdie beginsel is natuurlik baie sterk afgekeur deur die Mediese Vereniging. En sake is vererger toe een van die maatskappye begin het om tjeks ten opsigte van hul versekerde lede aan te bied op die basis van die voorkeurtarief terwyl hulle van die dokters verwag het om die tjeks aan te neem ‚in volle vereffening' van hul rekening. Dié toestand van sake het groot ontevredenheid veroorsaak by lede van die Mediese Vereniging en kon nie aanvaar word nie.

'n Lang reeks van moeilike onderhandelinge het nou gevolg. Vir die Mediese Vereniging was die toestand vol dilemmas, aangesien sy eie lede so verskil het oor die saak.

Baie lede het byvoorbeeld die genoemde tjeks aanvaar, terwyl ander lede die tjeks op beginsel nie wou aanvaar nie. Dit was moeilik, feitlik onmoontlik, vir die Mediese Vereniging om met die versekeringsmaatskappye te onderhandel op 'n basis wat hulle sou aanvaar en wat *al* die lede van die Vereniging terselfdertyd sou tevrede stel.

Die Mediese Vereniging het dus die enigste weg gevolg wat vir hom moontlik was — hy het naamlik deur sy verteenwoordigers bly onderhandel volgens die lig wat hy gehad het, en altyd met die oog daarop om amptelik niks te doen wat die waardigheid van die Vereniging en die professie sou skaad nie.

By sy laaste vergadering op Vereeniging, het die Federale Raad 'n groot aantal groepe wat deur die twee versekeringsmaatskappye geadministreer word, as hulpverenigings goedgekeur. Dit moet onthou word dat al hierdie groepe voldoen het aan die vereistes van goedgekeurde mediese hulpverenigings. Dit het egter geblyk dat dit met die oog op toekomstige onderhandelinge geriefliker sou wees vir die versekeringsmaatskappye om te voldoen aan 'n inkomsteperk vir hul lede op wie die voorkeurtarief van toepassing sou wees. Die bestaande mediese hulpverenigings sou nog voldoen (soos voorheen) aan 'n gemiddelde inkomstesyfer van hul lede.

Die Vereniging het deur die Uitvoerende Komitee van sy Federale Raad besluit om 'n perk van £2,300 te aanvaar as basis van onderhandeling. Die Vereniging is bewus dat baie lede nie hiermee sal saamstem nie, maar êrens moes tog 'n besluit geneem word op grond waarvan verdere onderhandelinge gevoer kan word. Op hierdie stadium het die onderhandelinge met die Suid-Afrikaanse Onderlinge Mediese Hulpvereniging egter totaal afgebreek, aangesien hierdie hulpvereniging onder andere nie die gekodifieerde tjek nou wil terugtrek nie.

Die toestand van sake staan dus, om op te som, op die oomblik soos volg:

1. Die goedgekeurde mediese hulpverenigings wat op hul eie funksioneer en wat nie deur versekeringsmaatskappye onderskryf word nie, bestaan en word nog erken soos voorheen. Uitbetalings vir dienste aan hul lede word, soos in die verlede, gemaak op die basis van die voorkeurtarief. 'n Lys van hierdie hulpverenigings is gepubliseer op bladsy 1062 van die uitgawe van die *Tydskrif* van 10 Desember 1960.

2. 'n Groot aantal groepe wat in alle opsigte voldoen aan die vereistes van mediese hulpverenigings, maar wat deur SANSOM geadministreer word, is goedgekeur by die laaste vergadering van die Federale Raad. 'n Lys van hierdie groepe is as Byvoegsel tot die *Tydskrif* gepubliseer op 26 November 1960. Aangesien hierdie groepe voldoen aan die vereistes van goedgekeurde mediese hulpverenigings, sal dokters op die basis van die voorkeurtarief vir hulle direk en ten volle uitbetaal word.

3. In beginsel is die perk van £2,300 aanvaar vir die goedkeuring van *verdere* groepe wat deur SANSOM geadministreer word.

4. Geen goedkeuring word meer verleen aan enige groep wat deur die Suid-Afrikaanse Onderlinge Mediese Hulpvereniging verseker is nie, aangesien alle onderhandelinge nou met hierdie hulpvereniging beëindig is, soos ons aangetoon het en soos ook verduidelik is in die amptelike verklarings en die rubriek van die Sekretaris wat op 14 Januarie 1961 op pp. 35 en 36 van die *Tydskrif* verskyn het. Die groepe wat deur hierdie vereniging geadministreer word en wat voorheen goedgekeur was as mediese hulpverenigings (p. 1064, *Tydskrif* van 10 Desember 1960), verval nou ook as goedgekeurde groepe.

5. Die Mediese Diensplan, wat die ondersteuning van die Vereniging geniet, is op die oomblik in werking op die Witwatersrand, as eksperiment.

Dit sal sake vir die onderhandelende Komitee baie vergemaklik as lede van die Vereniging nie persoonlike ooreenkomste met die maatskappye of hul agente aangaan nie maar liewer hul moeilikhede by hul takvergaderings bespreek en/of hulle na die Hoofkantoor van die Vereniging verwys.

Langs hierdie weg wil ons by herhaling 'n dringende beroep op alle lede van die Mediese Vereniging doen om die Vereniging in sy moeilike taak te ondersteun. Daar sal miskien nog vir 'n tyd lank onsekerheid heers, maar vordering in belang van die lede word nog steeds gemaak. Slegs deur almal saam te staan kan ons verhoed dat ons as professie oorheers word deur die belange van groot sakeondernemings. En slegs deur saam te staan kan ons reg laat geskied aan die behoeftes van ons pasiënte en aan onsself — en ook waak daarteen dat die waardigheid van die professie ondermyn word.