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Practitioner perceptions about optometric networks in South Africa

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Background: Private healthcare in South Africa is largely financed by medical schemes. Optometrists reluctantly contract with administrators and networks to service these patients, despite them feeling networks are undesirable and exploitative. Networks contend that various mechanisms employed are necessary to ensure sustainability and prevent fraud, wastage and abuse. A working relationship between practitioners and networks should ideally be cordial and appreciated by each party as being mutually beneficial to the success of their respective businesses.

Aim: To assess practitioners' knowledge and perceptions regarding optometric networks.

Setting: The study was conducted amongst optometric professionals in the private sector in South Africa.

Methods: A descriptive, mixed-method study was conducted using a semi-structured questionnaire. Interviews with senior personnel from the networks were conducted.

Results: Approximately 77% of respondents belonged to networks with 91% being knowledgeable about networks and their role within optometry. Opticlear had 72% members, while Iso Leso and preferred provider negotiators (PPN) had 67% and 41%, respectively. Most optometrists (69%) neither believed in the need for networks nor that they provide value to the profession, while 94.7% joined networks merely to receive direct payment and access patients, with no other benefits noted.

Conclusion: Practitioners reluctantly contract to networks for direct payment and to access patients. Furthermore, practitioners feel that networks bully and victimise them while networks highlight their responsibility to reduce healthcare costs and negative practices of fraud, waste and abuse.

Contribution: Providing sustainable, cost-effective and quality eye care services requires collaboration between networks and practitioners and appreciating each other's roles in the delivery of eye care services.

Keywords: networks; managed care organisations; designated service providers; *Medical Schemes Act*; Health Professions Council of South Africa; South African Optometric Association.

Introduction

Private healthcare services, including optometric services, are largely pre-funded by private medical aid schemes and insurances.[1] The schemes either self-administer optometric benefits for their beneficiaries or outsource the administrative functions to third-party companies known as administrators, networks, designated service providers (DSP) or managed care organisations (MCO).[2] Some schemes only sub-contract managed care services for different diseases to different MCO, while others will have one MCO providing holistic managed care services for its beneficiaries.[3] Although there are many administrators, networks and MCO active in optometry, there are three major networks who exclusively administer optometric benefits and to whom optometric professionals contract with, namely, Preferred Provider Negotiators (PPN), Iso Leso and Opticlear. This contractual arrangement enables optometrists to provide services to beneficiaries of medical aid schemes that have outsourced their administrative functions to the respective networks.

Option to participate (OTP) contracts with a network require participating providers to agree to predetermined tariff structures, reimbursement at levels that are often discounted below market rates and to conform to certain clinical protocols. Generally, practitioners reluctantly sign participation agreements to be able to receive direct payment and be endorsed to deliver eye care

services to the respective medical scheme's beneficiaries. Practitioners often complain of unfair treatment meted out to them by the medical schemes, administrators and networks. The widespread dissatisfaction and perceived seriousness of their complaints were not exclusive to optometry as, in 2019, other healthcare disciplines also reported experiences of unfair treatment that escalated to the establishment of a Section 59 Commission of Inquiry into unfair and racial biases against some practitioners, especially when conducting audits and peer review activities.[4]

Healthcare services are funded by a diverse mix of public and private funding systems with different levels of access, affordability, patient care and health outcomes.[5] In the United States (US), the private sector accounts for more than half of the total healthcare expenditure, which is largely funded by big national insurance companies.[6] Similarly, South Africa has a two-tiered healthcare financing system characterised by a relatively large proportion of funding allocation (81%) and spending used to procure private healthcare services for 16% of the population within the private health sector.[7,8] This occurs through medical insurance schemes and other out-of-pocket payments (OPP). Barriers to access include affordability, enabling only those with financial means to procure medical cover independently or through places of employment. Although access to medical schemes is now open to all, medical cover and private hospitals were restricted only to white South Africans up until the 1970s.[9]

Medical schemes are established and regulated under the *Medical Schemes Act*, *No 131 of 1998* (MSA) and fall under the jurisdiction of the Council for Medical Schemes (CMS), an independent statutory body that reports to, and advises the Minister of Health on appropriate regulatory and policy interventions to achieve national health policy objectives.[1,2,5] Medical schemes contract administrators, networks, DSP and MCO to administer healthcare benefits in accordance with the provisions of the *Medical Schemes Act no 131 of 1998 Regulations*.[2,3] Designated service providers refer to a healthcare provider or group of providers, contracted to the medical scheme concerned as the preferred provider or providers to provide to its members or beneficiaries healthcare services at an agreed reimbursement rate.[2,10]

Networks and MCO within optometry provide administrative functions to medical schemes by ensuring that their beneficiaries receive eye care services through practitioners within their respective networks, known as DSP. Managed care is defined by Regulation 15 of the *Medical Schemes Act*, *131 of 1998*, as 'a clinical and financial risk assessment and management of healthcare, with the view to facilitating appropriateness and cost-effectiveness of relevant healthcare services within the constraints of what is affordable, through the use of rule-based and clinical management-based programmes'.[2,11] Accordingly, any person or entity, contracted by the medical scheme to provide managed healthcare services in terms of regulation 15(A) of the MSA, is referred to as an MCO.[2]

Managed care originated in the last century, when the railroad, mining and lumber companies organised their own medical services or contracted medical groups to provide care for their workers.[12] The prospect that managed care systems would provide medical cost savings of between 20% and 40% motivated government administrators and large employers, who financed insurance for their workers, to managed care systems. Motivated by a rationale that the cost of healthcare was escalating uncontrollably, such systems became prominent in the 1970s in the US.[13,14,15] During this period, Europe and other global governments also attempted to find ways of limiting costs without compromising the quality of healthcare.[9,11]

In the South African market, managed healthcare emerged in the 1990s, as a cost-reduction mechanism,[14] although the *Medical Schemes Act*, *No 131 of 1998* incorporated managed care for the first time in 2000. It was introduced as a solution to the cost escalation problems inherent in the existing third-party payment fee-for-service (FFS) system of health finance in the private sector.[16] Optometric benefits are administered by for-profit entities like administrators, on an FFS basis, and networks and MCO usually on capitation arrangements, which are agreements whereby a medical scheme pays the organisation a fixed fee per patient in return for delivery of specified healthcare services or benefits to all or any members of a scheme.[11] Optometric networks have provided managed care services for at least three decades, with Opticlear,[17] Preferred Provider Negotiators[18] and Iso Leso[19] having 30, 28 and 24 years of expertise in the optical environment, respectively.

A health management organisation (HMO) and preferred provider organisation (PPO) are the common types and most recognised of managed care structures.[12,16] An HMO is a prepaid organised healthcare delivery system where a fixed amount of money is agreed upon and made available to cover the healthcare needs of members, with the HMO assuming the financial risk; transferring some to providers.[12] A PPO is an entity through which employers and payers contract with a selected group of providers (preferred providers) to purchase healthcare services for their members at a discounted, predetermined fee.[12] Participating providers usually agree to abide by utilisation management and other procedures implemented and agree to accept the PPOs' reimbursement structure and payment levels.

Managed care organisations use various utilisation management strategies to control the use of services.[12] The basic idea is to review and supervise expensive decisions, ensuring that they are in accordance with prescribed guidelines. Doctor profiling, feedback on utilisation performance, use of formal written practice guidelines and various types of utilisation reviews are most commonly used by the networks.[12] In 2019, PPN published its network manual spelling out guidelines on utilisation reviews and other operating protocols with the supporting rationale defined. This led to unhappiness within optometry,

prompting a boycott of the network and numerous resignations.[20] Although the anger was largely directed at PPN, other networks too were accused of practitioner ill treatment. This period, characterised by a general dissent with medical administrators and MCOs, led to the creation of the Section 59 Investigation by the CMS.[4] Over time, little attention was paid to the relationships and structure of the system within which care was provided and the dynamics between and among role players.[21] The polarisation within an industry that should be working together and the noted absence of scholarly literature investigating some of the core issues underpinning the discourse led to this study, the aim of which was to assess practitioners' knowledge and perceptions regarding optometric networks in South Africa.

Methods

The study employed a mixed-methods, descriptive study approach, combining the use of both qualitative and quantitative methods within the paradigm.[22,23,24,25] The study population included optometrists and dispensing opticians currently registered and practising optometry or dispensing opticianry, respectively, in good standing with the Health Professions Council of South Africa (HPCSA) and owning private practices. To avoid bias, participants were both members and non-members of the South African Optometric Association (SAOA). With no accurate reliable database of practising healthcare practitioners in South Africa,[26,27] the average estimates of practices in South Africa between the networks and the SAOA were 2200 from which the sample was drawn. The sample size was estimated to be 240 with a confidence interval of 95% and a 5% margin of error.[24,28,29,30] Quantitative data were collected from optometric professionals by way of a semi-structured questionnaire. The questionnaire comprised three sections: firstly of which collected demographic information, secondly looked at practitioner knowledge of networks and thirdly sought to explore the perceptions of optometrists on the networks in South Africa. Most questions were closed ended, and where more information was required, open-ended questions were asked. Data were captured, processed, coded and analysed using the Stata® Version 14.2 software. Descriptive statistics were used to analyse and present the collected quantitative data.

For qualitative data, a purposive sampling strategy was employed where senior personnel from selected MCO or networks were invited to participate, based on their expertise and position within their organisations. Individual key stakeholder interviews were conducted with personnel in a natural setting. Responses from open-ended questions collected in the questionnaires, as well as from the interviews, were captured, coded and analysed using thematic content analysis, where key themes that commonly appeared in the responses were identified in accordance with qualitative data analysis strategy using themes.[28,31,32] Consent to participate was obtained; participation was voluntary and individual confidentiality maintained.[24,28,30,33,34]

Ethical considerations

Ethical clearance to conduct the study was obtained from the University of KwaZulu-Natal (UKZN) Humanities Ethics Committee (HSS/0228/018M). Informed consent was given by participants before proceeding to participate in the study.

Results

Although the key focus of the study was to ascertain practitioners' knowledge and perceptions of networks, interviews were also conducted with senior representatives of two of the three networks to understand their core business, roles within the optometric sector and challenges experienced in administering optometric benefits. Analysis of coded questions resulted in the emergence of three dominant themes, namely, ensuring availability of optical benefits, ensuring the correct benefit is paid to the appropriate practitioner and combatting fraud, waste and abuse.

In responding to questions relating to their core business, respondents indicated that their core business was to negotiate a fair medical aid patient benefit and fair reimbursement to the contracted practitioner, within the confines of Regulation 15 of the *Medical Schemes Act 131 of 1998*. Additionally, they indicated a responsibility to identify and minimise fraudulent and abusive claims, stressing that their primary client is the medical aid scheme and that they additionally represent the financial interests of their shareholders.

Networks identified irregular claim patterns as one of the challenges facing the sector and highlighted that many practitioners fall victim to this problem. Furthermore, that they have demonstrated, through their actions, an emphasis on combating what is known in the healthcare sector as fraud, waste and abuse. They have employed different mechanisms such as audits and peer review processes to fight these and ultimately rid the industry of unethical practices.

Although the two participating networks are providing a service to medical schemes, which are regulated under the MSA, both conceded that they were not accredited as MCO as required by Regulation 15 of the *Medical Schemes Act*.

A total of 174 respondents completed the online questionnaires, of whom the majority (56%) were SAOA members, with 52% being males and 48% being females. Affiliation or not with the SAOA had no influence on the choice on membership of networks. The modal age group was 41–50 years old (39%) and a few 70 years and older (5%). The mean age of respondents was 42.76 years (standard deviation [s.d.] = 9.31 years), and the median age was 42.83 years. Figure 1 shows the age distribution of respondents.

Most respondents confirmed their discipline as optometry (98%) and only 2% were dispensing opticians. Most respondents (84%) were in independent or solo practice, 6% in group practices and the remaining 10% were in franchised practices. Gauteng had the highest number of respondents

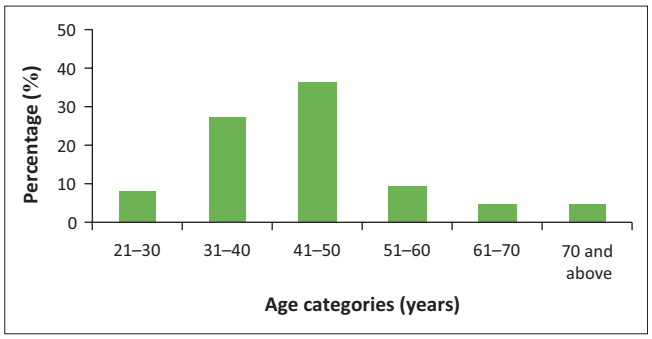


FIGURE 1: Respondent age categories in years.

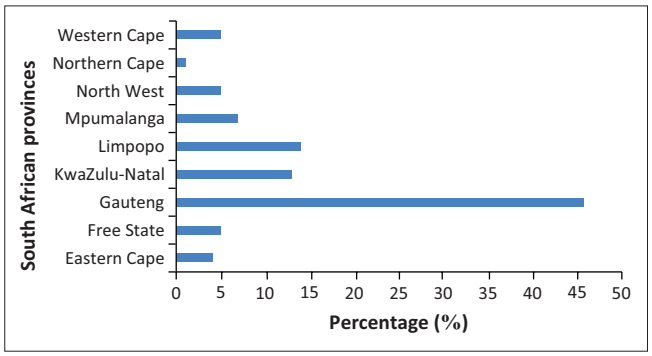


FIGURE 2: Percentage distribution of respondents per province of South Africa.

(46%) followed by Limpopo and KwaZulu-Natal provinces with 14% and 13%, respectively (Figure 2).

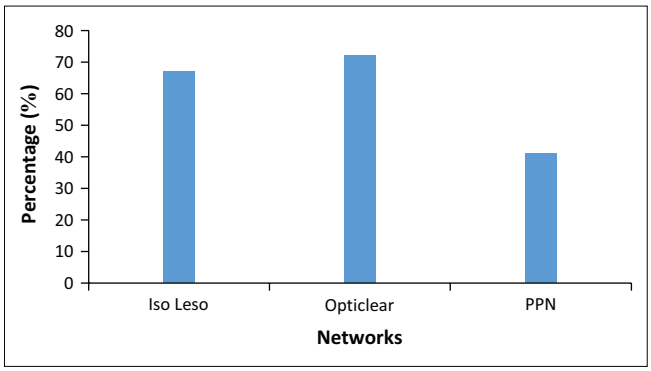
Respondents who practised in the cities constituted 40%, towns (36%), townships (16%) and the remaining 8% practised in rural settings as defined in Statistics South Africa's 2001 Census Concept definition document.[35]

More than three-quarters (77%) of respondents belonged to one or more networks with 91% of them stating that they learnt of networks from the medical aid schemes, through the process of submitting optical claims. Of the respondents who belonged to networks, more than half of them (53%) were members of the SAOA. Opticlear had the largest membership, with 72% of the respondents being members, and PPN had the least (41%), as shown in Figure 3.

Most respondents (69%) indicated that there is no need for networks in optometry practice, even though more than three-quarters (77%) of them were members of such networks, and 88% did not think that the networks protected the profession. When asked as to why they were members of networks, the following were the two most common reasons for affiliation that emerged:

- Access to medical aid patients

  The main reason that most respondents (94.7%) indicated as motivation for them joining any of the networks was that it was the only means whereby they could get access to members and beneficiaries of the contracted medical aid schemes. They further explained that patients were channelled by the networks to their respective 'in-network providers' or sometimes just prevented from consulting with 'out-of-network providers', financially disadvantaging them.



PPN, preferred provider negotiators.

FIGURE 3: Network membership distribution.

- Direct payment

  The second common reason cited was that, although they did not want to be members of the networks, they were compelled to join for specific financial reasons. The rationale being that only if they are part of the network would they be paid directly by their contracted medical schemes, for services rendered to their members and dependents.

Some respondents further elaborated on reasons why they thought networks are not needed by making statements such as 'networks are self-profiteering vultures preying on practitioners and they set unreasonable and exclusionary conditions that must be met before acceptance'. Others added that networks 'exploit practitioners' and 'abuse their power and information'. Many claimed duress in their decision to participate in networks as they are generally presented with a forced-choice situation whereby, if they choose not to join, they ran the risk of losing a significant proportion of their patient base. There were no positive sentiments cited as additional comments on any of the network questions.

Respondents repeatedly raised two issues on their perceptions of the general relationship between practitioners and networks:

- Bullying and exploitation

  Most respondents (69%) voiced their disappointment with the *modus operandi* of the networks regarding the general treatment of respondents, with many citing that they feel that they are 'treated like criminals' and are exposed to networks 'dictating things without opening a window of negotiation with the practitioners'. Networks were accused of being police officer, investigator, prosecutor and judge when it pertains to dealing with cases relating to reviews and audits.

- Undue discounting

  Two-thirds (66%) of the respondents felt that the discounting that the networks impose on the tariffs is

affecting the financial viability of practices and making them unsustainable. They elaborated further that managed care tariffs were already low and discounted, so further discounting was a problem. There was a general view that suggested that respondents perceived all the networks as being exploitative in their nature.

When asked whether the practitioners and/or practitioner groups were involved or engaged by networks when setting the tariffs, only 1.5% of respondents thought that the practitioners were consulted by networks when determining and setting the tariffs, while 9.5% of respondents were unsure whether practitioners had a say on the tariffs and 89% of them responded that practitioners played no role.

Discussion

This study found that respondents' age, gender and/or affiliation with the SAOA did not influence a decision on whether to join a network or not. One may have expected that more of the SAOA members will join as the SAOA advocates and lobbies various stakeholders, including networks, on behalf of its members on a range of issues, not limited to fair benefit allocation, clinical protocols and standards of care and coding. Although over three-quarters (77%) of the respondents are members of one or more of the optometric networks, responses from 94.7% of respondents indicated that their membership is a grudge membership, seen as purely for access to medical schemes beneficiaries and financial survival. There appears to be no true organisational value in networks identified by practitioners. The very strong negative sentiments about the existence, influence and approach of the networks imply that if there was an alternate mode for respondents to get access to medical aid patients and be paid directly for services rendered, networks could cease to exist. A strong view shared by 80.2% of general practitioners (GPs) who stated that if there were no financial considerations, they would not contract with MCO and therefore there would be no need for managed healthcare.[15]

Among the study respondents, PPN had the lowest numbers in network membership compared to its competitors although they claim to have the largest membership.[18] This may be because of the challenge that occurred with the introduction of the 2019 amended PPN manual.[20] The amendments, which included operational changes such as discounting, procurement of lenses, verification of validity of services and controlling mark-ups, led to strong discontent within the optometric profession resulting in mass resignations from the network. Perhaps better engagement that canvassed practitioner opinions prior to the implementation of the amendments may have prevented the resulting practitioner exodus. Of additional concern was the fact that there were no positive sentiments cited on networks, highlighting a need for relationship-building initiatives. It is important that practitioners inform themselves adequately about the detailed policies and operational strategies as well as their practitioner rights, as many are misinformed in thinking that it was compulsory to be a member of a network.

Managed care organisations and PPO act as intermediaries between the purchasers of healthcare services (medical aid schemes) and selected preferred providers (the participating practitioners), who agree to provide services on a discounted fee basis.[12] However, practitioners have expressed dissatisfaction with the fact that over and above the prescribed reduced or discounted tariffs that their participation agreement stipulates, the additional discounts that the MCO levy are unjustified and unreasonable. The supposed choice given to patients to be able to consult with those providers who are not preferred providers or in-network providers, referred to as DSP is considered moot as they are effectively coerced by the network to go to their providers through incentives and disincentives.[12] Although the use of non-DSP providers is discouraged as it attracts a financial penalty to the patient in the form of shortfall co-payments and levies, there are some exceptional circumstances where non-DSP can be consulted by patients and reimbursed by schemes such as in an area where there is no DSP provider.[10] In these specific circumstances, DSP agreements allow medical scheme beneficiaries access to fully covered healthcare services while the healthcare provider benefits from direct payment arrangement and increased patient volumes.[10]

As with any other profession, users of health services are aware that practitioner competence levels vary, a factor that generally plays a significant role in the selection of service providers. The financial penalties meted out to patients, in an economically constrained environment, for choosing to consult a practitioner of their choice, deprive them of receiving care from a practitioner that they may consider more competent than those on the network list. Decisions made by these networks should always factor in patients' rights. Although it is understood that both healthcare practitioners and patients have the freedom to choose the treatments they use or prescribe, the motivation to achieve cost effective and quality care where incentives could influence practitioner behaviour, thereby posing a threat to the autonomy of the patient and practitioner. This choice may be indirectly influenced and limited by the unavailability of funding and benefits.[15,36]

There was general unhappiness by respondents regarding the existence of networks with the majority (69%) being of the view that networks are not needed in the delivery of healthcare services in the private sector. The perceptions of optometric professionals are that the networks do not enhance or provide value to the profession and are irrelevant or undesirable in the profession because of the way they conduct their business as well as treating practitioners negatively. An earlier study among physicians also had a generally negative view of managed healthcare and almost 81% of them disagreed that managed healthcare has improved medicine (48% strongly disagreed and 32.9% disagreed).[15] Most (88.7%)

felt that managed healthcare system impacted on the practitioners' rights to deliver healthcare services as they deem necessary and 78.2% felt that managed healthcare systems could result in unethical actions by practitioners, such as underservicing with 73.6% contending that under managed healthcare system patients are underserviced.[15] This is, however, contradicted by the findings of the survey conducted by the Health Market Inquiry (HMI) with GPs, which found that 53% of surveyed GPs did not believe that the quality of healthcare was negatively impacted on by managed healthcare interventions.[26] While 88% of respondents in the current study did not believe that networks protect the optometric profession, it is important they empower themselves with knowledge on the functions of networks as 'protection of the profession' is not the function of networks but rather that of their respective professional associations or regulatory bodies.

Networks identified billing and coding as constituting most of the transgressions to which respondents fall victim. This view is validated by a study that found that most of the fraudulent claims are perpetrated through the submission of false claims, irregular billing of codes, duplicate claims, claiming for services that were not rendered and card farming, which refers to members utilising medical aid benefits for a person not covered on the medical aid.[37] Nortjé and Hoffmann[38] also had similar findings and further noted that optometry recorded the third-most transgressions within the HPCSA, second to psychology and the medical professions, respectively. The negative impact of fraud on healthcare and healthcare financing is that it threatens sustainability and security of providing healthcare by driving up the cost of healthcare, impeding the provision of universal access to quality, affordable and timely healthcare.[1,39,40,41,42] This is a grave indictment on the profession and efforts should be made by all sectors of organised optometry to create awareness and foster compliance through continuous engagement with practitioners on professional ethics.

A lack of coherence in the health system, organisational fragmentation, excessive resources utilisation (wastage), the lack of preventive services, growing incidents of under-treatment or over-treatment of patients and weak clinical accountability motivated the development of managed care,[12] in which comprehensive, preventive, promotive, rehabilitative and curative care are managed.[11] Networks have maintained a view that the practice of practitioner profiling and peer review is essential in ensuring that appropriate benefits are paid to the right treating practitioner. Formal written practice guidelines, practice profiling and other utilisation review tools to monitor abusive and wasteful practices by providers and patients, consumer education and incentives to reduce unnecessary healthcare utilisation, controlled access to expensive services and negotiating discounts on supplies and services are used to manage escalating costs.[12,16] The disgruntlement of practitioners in relation to profiling and utilisation reviews warrants effort by MCOs to meaningfully engage with practitioners to reach a common understanding on the purpose and need for these practices. All stakeholders in healthcare should appreciate each other's respective roles, responsibilities and obligations towards each other because to achieve the ultimate goal of delivering quality, universally accessible and sustainable healthcare they should function in recognition and respect of each other.[36]

The concern by the majority (66%) of the respondents that the additional discount forced on to the already reduced tariffs is driving the practices out of sustainability corroborates findings from a study in the US that found that organised medicine viewed the emergence and rise to prominence of corporate medicine and intermediaries between doctor and patient as a threat to medical autonomy and potential loss of profits.[12] It is also noted from practitioners that, at this point, medical aid benefits and tariffs are determined arbitrarily between the medical aid schemes and the networks without consultation with or input from practitioners. This contradicts the findings of the HMI that suggested that practitioners have an opportunity to determine and influence the benefits and levels of remuneration for their services, a suggestion that should be heeded by optometric networks.[26]

Conclusion

The relationship between the networks and optometric practitioners appears to be an acrimonious one. Networks feel that there is practitioner engagement in undesirable business practices such as fraud that threatens their sustainability and funding of private healthcare services. Practitioners are dissatisfied with the treatment meted out by networks towards them and what they consider to be unreasonable financial structures. It is imperative that both parties engage meaningfully to foster a better working relationship. The SAOA and other professional representative groups should lobby the CMS for the networks and MCO to take up accreditation in terms of Regulation 15 of the *Medical Schemes Act, 131 of 1998*, so that they fall within a regulatory framework to ensure accountability and encourage responsible and ethical conduct. Practitioners must be constantly reminded about their ethical obligations and the negative impact of medical aid fraud, waste and abuse on the health system as a whole and on individual medical scheme members in an already constrained economic environment. Positive transparent working relationships between these important stakeholders can only augur well for eye care in the country.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

S.A.M. was the principal researcher and involved in concept development, data management and writing of the article. V.R.M. was the supervisor for the research project, aided with concept development and co-authored the article.

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Data availability

Data collected has been stored and kept safely protected, accessible by the authors. Data supporting the findings of this study are available from the corresponding author, S.A.M., on request.

Disclaimer

The views and opinions expressed in this article are those of the author(s) and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

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