CMS

Council for Medical Schemes

THE VALUE PROPOSITION OF DESIGNATED SERVICE PROVIDERS (DSPS) IN MEDICAL SCHEMES: A STRATEGIC ANALYSIS

Policy Research and Monitoring

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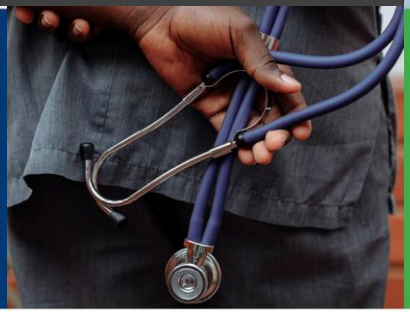

This document is released by the Policy Research and Monitoring Unit (PRMD) within the CMS. The PRMD serves both medical scheme beneficiaries and the general public. Its core responsibilities encompass the execution of research projects, data collection, and analysis to evaluate and monitor the sector's healthcare utilisation and performance and assess and report on emerging trends within medical schemes. The unit is additionally tasked with quantifying risk within these schemes and formulating recommendations to advance regulatory policy and implementation. Lastly, the PRMD actively contributes to developing policies that reinforce safeguarding the interests of both beneficiaries and the broader public. The research team comprises specialists with diverse expertise in health economics, statistics, epidemiology, public health, and financial analysis.

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EXECUTIVE SUMMARY

Background: Designated Service Providers (DSPs) have experienced notable growth over time, evolving into pivotal healthcare sector entities. Their influence on cost-containment strategies has impacted the financial landscape of healthcare systems. With each stage of their evolution, the significance of their contributions has grown, playing a pivotal role in shaping the strategies and financial frameworks essential to providing healthcare services. The changing role of DSPs within medical schemes, as delineated by the Council for Medical Schemes (CMS) in 2008 and underscored by recent research studies, highlights their transformative impact on the healthcare sector. This sequential evolution emphasises their increasing importance in developing strategies for sustainable and financially sound healthcare systems.

Study Objectives: The primary objective is to identify and analyse DSP-related complaints, explicitly focusing on non-payment and underpayment issues. The study aims to understand the root causes of member dissatisfaction, financial disputes, and communication breakdowns within the healthcare scheme.

Methods: This research examined 208 complaints associated with DSPs from 2018. The data were systematically categorised into two primary domains, non-payment and underpayment, with a specific emphasis on short payments as a notable concern. A mixed-method research design was employed, incorporating both qualitative and quantitative analyses. The qualitative aspect involved a thematic analysis of the complaints' synopsis, and the data underwent further classification based on the outcomes of the thematic analysis. Concurrently, the quantitative analysis encompassed descriptive analysis to briefly present the data and survival analysis to evaluate the time taken to resolve complaints.

Results: Examining complaints related to DSP uncovered two primary categories: non-payment and underpayment of claims. Underpayment emerged as the predominant concern, constituting 88% of DSP-related complaints, with non-payments comprising 22%. Notably, within the underpayment category, a significant portion—48% of all DSP-related complaints—was attributed to the short payment of complaints. More specifically, the short payment category was particularly pronounced in instances involving emergency claims categorised as PMBs and those related to chronic conditions diagnosed and treated during emergencies. Further breakdown of the short payment category revealed that claims associated with PMBs and emergency-related diagnoses, where non-DSP options were used involuntarily, contributed to 18% of the complaints. On the other hand, cases where non-DSP options were used voluntarily comprised 13% of the complaints. Short payments related to non-PMB-related complaints constituted 9% of the overall complaints in this category. This breakdown provides insights into the specific areas of concern within the underpayment spectrum, guiding potential targeted interventions and improvements in the DSP-related claims process. Survival analysis was performed to determine failure time and the Kaplan-Meier curves. Dispute Resolution and Assistance and Short Payment Disputes had median survival durations of 78 days (IQR 77-225) and 75 (IQR 39-202), respectively. The median survival time following emergency medical treatment was 158 days (IQR 60-261), suggesting a longer resolution time.

Findings: The study showed that complaints primarily revolved around the denial of funding for designated PMB conditions, encompassing critical medical procedures such as Neuropathic Bladder, amputation, and cataract treatment. Members faced significant hurdles when voluntarily opting for non-SPs, leading to funding disputes and further intensified by the absence of DSPs in residential areas. The lack of nearby DSPs poses inconveniences, compelling members to seek treatment at non-DSPs and triggering funding disputes, mainly when DSPs nearby are unavailable. Emergencies exacerbate conflicts, with members being denied urgent PMB treatment due to the non-use of DSPs, as they argue for immediate care at non-DSPs. Co-payment issues, especially chronic medication, amplify discontent among pensioners facing financial burdens. Further analyses reveal deeper concerns, including discrepancies in co-payment details, unexpected changes in chronic medication funding, dissatisfaction with service quality and DSPs, disputes over specific medical procedures, communication and information inadequacies, and perceived failures in settling PMB-related treatments. Members express frustration over the scheme's apparent inefficiencies in assisting and resolving disputes effectively, emphasising the need for improvements in communication, funding clarity, and overall member support.

Recommendations: In response to the identified challenges within member complaints, comprehensive recommendations are proposed to enhance the healthcare scheme's overall effectiveness and member satisfaction. First and foremost, communication strategies should be strengthened, emphasising the need to keep members well-informed about the availability of DSPs. Clear communication regarding the limitations associated with non-DSP usage and providing information on potential co-payments will contribute to a clearer understanding of healthcare benefits among members. Another critical recommendation involves expanding the Designated Service Provider network to offer members a broader range of accessible healthcare options while minimising reliance on non-DSPs, thereby creating a more comprehensive and convenient healthcare network. Optimising processes to ensure prompt member treatment without subsequent funding disputes is recommended in emergencies. Streamlined and efficient emergency procedures, while maintaining adherence to guidelines, are crucial for delivering timely medical care. Addressing financial concerns, particularly among vulnerable groups like pensioners, is essential. Therefore, a thorough evaluation of co-payment policies is recommended to create policies that enhance member satisfaction and alleviate the financial burdens associated with co-payments.

Lastly, enhancing the review procedures for PMB-related claims is crucial to prevent unnecessary disputes. This involves implementing a robust review process that ensures a thorough and timely assessment of critical medical conditions, facilitating prompt funding and appropriate care for members. Collectively, these recommendations aim to improve the member experience and contribute to resolving disputes and the long-term success of the healthcare scheme.

Conclusion: Strengthening communication strategies, expanding the Designated Service Provider network, optimising emergency processes, reviewing co-payment policies, and enhancing PMB review procedures collectively form a comprehensive approach toward creating a more responsive, member-centric healthcare system.

ACRONYMS AND ABBREVIATION

CDL	Chronic Disease List
CMS	Council for Medical Schemes
CompCom	Competition Commission
DSP	Designed Service Provider
DTP	Diagnostic Treatment Pair
HMI	Health Markert Enquiry
MCO	Managed Care Organisations
MSA	Medical Schemes Act
OMAC	Old Mutual Actuarial Consultants
OOP	Out-of-Pocket Payment
Non-DSP	Non-designated Service Providers
PMB	Prescribed Minimum Benefits

TABLE OF CONTENTS

FIGURES

TABLES

1. INTRODUCTION

The healthcare landscape is marked by dynamic challenges and opportunities that necessitate innovative approaches to healthcare management (Maphumulo & Bhengu, 2019). Medical schemes constitute a significant portion of healthcare expenditure in South Africa, representing a considerable share of the country's Gross Domestic Product (GDP) and providing coverage for less than 15% of the population (CMS, 2023). As medical schemes grapple with escalating costs, evolving member expectations, and pursuing enhanced healthcare outcomes, DSPs have emerged as strategic allies in addressing these complex issues. DSPs refer to a healthcare provider or a group of providers selected by a scheme as a preferred provider(s) to offer its members the diagnosis, treatment and care for PMB conditions (CMS, 2008). As the healthcare industry transforms, medical schemes increasingly turn to DSPs to address cost management, quality assurance, and member satisfaction challenges.

The increasing complexities of the healthcare landscape, including the introduction of advanced medical technologies, changing demographics, and the rising burden of chronic diseases, have placed immense pressure on medical schemes globally (Kruk, Gage, Arsenault et al., 2018). In this context, medical schemes seek strategic partnerships with DSPs to navigate these challenges effectively. DSPs, as entities that offer specialised services and manage provider networks on behalf of medical schemes, play a crucial role in reshaping the dynamics of healthcare delivery (CMS, 2008).

The inclusion of DSPs in the Medical Schemes Act of 1998 (Act 131 of 1998) aimed to promote collaborative arrangements between medical schemes and healthcare providers, ensuring the adequate provision of PMBs to beneficiaries across all schemes (MSA, 1998; M'bouaffou, Buch, Olorunju et al., 2022). Under this provision, patients opting to consult healthcare providers outside their medical aid scheme's contracted network are subject to a penalty co-payment (Goga, 2014; Mosiah, 2021). This consumer-facing penalty co-payment limits the freedom of choice for patients in selecting healthcare providers, negatively impacting their well-being and posing challenges to fair competition among various healthcare entities (Rivers & Glover, 2008; Goga, 2014).

The purpose of encouraging DSP arrangements was to streamline the delivery of essential healthcare benefits to beneficiaries, ensuring consistent access to PMBs (MSA, 1998; CMS, 2008; M'bouaffou, Buch, Olorunju et al., 2022). However, imposing penalty co-payments creates a financial disincentive for patients seeking services beyond the designated network. From a consumer's standpoint, this constraint on choice raises concerns about the potential curtailment of individual autonomy in healthcare decisions. A 2010 industry survey conducted by Old Mutual Actuarial Consultants revealed that 60% of surveyed medical scheme members expressed a negative sentiment toward DSP (Old Mutual Actuarial Consultants (OMAC), 2010; Goga, 2014). The primary reasons cited for this dissatisfaction included a desire for "freedom of choice" by 31% of respondents, 13% expressing the preference "to see their own doctor," and 9% finding the arrangement "inconvenient." (OMAC, 2010).

Furthermore, the penalty co-payment system introduces a layer of financial burden on patients, potentially influencing their healthcare provider choices based on economic considerations rather than medical preferences (Goga, 2014). This financial constraint may disproportionately affect vulnerable populations, limiting their access to a broader spectrum of healthcare providers. Understanding the contributions of DSPs is essential for medical scheme members, medical schemes, administrators, medical service providers and stakeholders involved in healthcare management (Goga, 2014; Mosiah, 2021). Despite the growing prevalence of DSPs in the healthcare ecosystem, there is a lack of comprehensive analysis of the multi-layered impact of DSPs on medical scheme members. This study seeks to address this gap by examining the value proposition that DSPs bring to the forefront of medical scheme operations.

2. RATIONALE

The rationale for this research stems from the pressing need to address and understand the multifaceted challenges posed by DSP-related complaints within medical schemes in South Africa. The healthcare landscape is inherently complex, and complaints related to non-payment and underpayment play a crucial role in highlighting deficiencies in the system (Reader, Gillespie, Neves et al., 2020; CMS, 2023). This study is motivated by the desire to gain comprehensive insights into the nature of these complaints, particularly within the framework of DSPs, which are pivotal components of the healthcare scheme. Firstly, non-payment and underpayment complaints represent significant friction between healthcare providers and members. Understanding the root causes of these disputes is essential for fostering improved relationships between stakeholders, ultimately leading to enhanced service delivery and member satisfaction.

Secondly, their integral role in healthcare provision justifies the focus on DSPs. DSPs are key entities within the healthcare scheme, and complaints about them offer valuable insights into members' challenges in accessing and utilising healthcare services. Examining non-payment and underpayment within the DSP framework provides a nuanced understanding of the intricacies of funding critical medical treatments. Moreover, this research aims to contribute to the existing body of knowledge on healthcare financing dynamics, member grievances, and potential areas for improvement within the operational framework of the medical scheme.

3. PURPOSE

This research aims to thoroughly examine complaints related to DSPs within the context of a healthcare scheme. The primary focus of the study is on scrutinising issues concerning non-payment and underpayment within the DSP to comprehend the intricacies of these challenges and their implications for the overall functionality of the medical scheme. The investigation entails the analysis of valid complaints registered in 2018, emphasising the delineation patterns and themes related to the non-payment and underpayment of benefits as a central concern. The study delves into the impact of non-payment and underpayment issues within DSPs on members' financial protection, especially for costly procedures that individuals may be unable to cover independently.

Through these analyses, the research seeks to contribute valuable insights to the existing body of knowledge concerning the dynamics of healthcare financing, member grievances, and potential areas for improvement within the operational framework of the medical scheme.

4. RESEARCH OBJECTIVES

This research aims to achieve the following objectives:

- Conduct a comprehensive analysis of DSP-related complaints, emphasising non-payment and underpayment challenges.
- Systematically categorise and reclassify complaints, focusing on PMB funding denial, emergency treatment disputes, co-payment dissatisfaction, and communication issues.
- Employ a mixed-method research design, integrating qualitative thematic analysis and quantitative descriptive and survival analyses on valid 2018 complaints.
- Provide a holistic understanding of DSP-related challenges, contributing valuable insights to existing literature on healthcare financing dynamics and member grievances.

5. KEY DEFINITIONS AND TERMINOLOGY

TERM	DEFINITION
DESIGNATED SERVICE PROVIDERS (DSPS)	Healthcare providers officially recognised by the healthcare scheme to deliver specific medical services to its members (CMS,2008). DSPs are crucial in this research as they form the basis for complaints and analysis within the healthcare scheme.
PRESCRIBED MINIMUM BENEFITS (PMB)	A set of defined healthcare benefits that must be provided by the healthcare scheme to its members (MSA,1998). PMBs include essential medical treatments and conditions. Understanding PMBs is vital as complaints often revolve around denying or underfunding PMB-related services.
CO-PAYMENTS	Payments made by healthcare scheme members for covered services usually a percentage of the total cost (Berman & Giardino, nd; Profmed, 2016). Co-payments are significant in complaints, especially when disputes arise over the amount or necessity of these payments.
NETWORKS	A group of healthcare providers, including hospitals and physicians, have agreements with the healthcare scheme to provide services to its members.
CHRONIC DISEASE LIST (CDL)	A list of medical conditions requiring ongoing medical attention and treatment (MSA, 1998). CDL is pertinent to complaints, particularly regarding chronic medication funding and disputes.

DIAGNOSTIC TREATMENT PAIR (DTP)	A combination of a diagnostic code (ICD-10) and a treatment code used for classifying medical services (MSA, 1998). Understanding DTP is crucial for analysing complaints related to specific medical procedures and treatments.
INVOLUNTARY USE OF A NETWORK	Instances where members are compelled to use healthcare providers within the designated network due to the unavailability of other options. (Mngadi, Wolvaardt & Thsehla, 2019). This term is vital for understanding complaints related to the forced usage of DSPs.
VOLUNTARY USE OF A NETWORK	Situations where members willingly choose to use healthcare providers within the designated network (Mngadi, Wolvaardt & Thsehla, 2019). This concept is relevant for analysing complaints about members opting for non-DSPs voluntarily.

6. METHODS

This study examined complaints related to DSPs reported during 2018 within the healthcare context. To understand the nature of these grievances, the data were systematically categorised into two main dimensions: non-payment and underpayment, with a specific focus on instances of short payments identified as a significant concern. This categorisation aimed to capture the diverse spectrum of challenges and conflicts within the DSP framework. The research methodology adopted a mixed-method approach, incorporating both qualitative and quantitative analyses to derive nuanced insights (Guetterman, Fetters & Creswell, 2015; Dawadi, Shrestha & Giri, 2021). Qualitatively, a thematic analysis was employed to scrutinise the synopsis of the complaints (Braun, & Clarke, 2006 ; Kiger & Varpio, 2020). This in-depth qualitative exploration allowed for the identification and categorisation of key themes emerging from the reported issues, providing a qualitative lens to understand the underlying complexities and nuances associated with DSP-related complaints (Creswell, 2014; Guetterman, Fetters & Creswell, 2015; Moser & Korstjens, 2017; Vasileiou, Barnett, Thorpe et al. 2018;). Furthermore, the qualitative findings were used to guide the subsequent quantitative analysis.

Quantitatively, descriptive analysis was applied to summarise the dataset, providing a quantitative overview of the distribution and patterns within the complaints (Cooksey, 2020). This statistical approach facilitated the identification of prevalent trends and patterns in the issues raised by complainants. Survival analysis, a statistical technique commonly used in healthcare research to assess the time until an event of interest occurs, was employed to evaluate the duration taken to resolve complaints (Cox, 1984; Myers, 2007; Singh & Mukhopadhyay, 2011). This quantitative component aimed to provide insights into the temporal aspects of addressing and resolving reported issues, contributing to a comprehensive understanding of the efficiency of the resolution process.

This mixed-method research design allowed for a holistic exploration of DSP-related complaints, combining the richness of qualitative insights with the precision of quantitative analysis. An all-encompassing strategy is essential for understanding the complex nature of difficulties in the DSP framework and guiding specific measures to enhance healthcare service delivery.

This research contributes to the existing body of literature on healthcare complaints and dispute resolution, offering valuable insights for policymakers, healthcare administrators, and researchers striving to enhance the effectiveness of healthcare procurement systems.

7. INCLUSION AND EXCLUSION CRITERIA

The inclusion criteria for this study involved selecting valid complaints related to DSPs in medical schemes, specifically focusing on issues of non-payment and underpayment. The final sub-sample analysis was based on valid complaints closed in 2018. The selected complaints were required to contain sufficient information to thoroughly examine the underlying issues and themes. Exclusion criteria were applied to filter out irrelevant or incomplete complaints that did not align with the study's focus. Complaints unrelated to DSPs, non-payment, or underpayment were excluded. Additionally, any complaints lacking essential details, such as the nature of the grievance or the specific conditions involved, were excluded to maintain the quality and reliability of the data. These inclusion and exclusion criteria ensured that the selected complaints provided a comprehensive and meaningful basis for the thematic analysis, aligning with the research objectives and contributing valuable insights to the study.

8. LITERATURE REVIEW

Over the years, DSPs have evolved into significant players in healthcare, particularly within the domain of medical schemes (CMS, 2008; Maluleke & Moodley, 2023). Their role in implementing cost-containment strategies has profoundly influenced the financial landscape of healthcare systems. As outlined by CMS in 2008 and 2014, DSPs primarily negotiate contracts with healthcare providers for medical schemes, seeking favourable terms aligned with cost-containment objectives. Establishing hospital networks allows medical schemes to negotiate preferential tariffs, mitigating the impact of rising healthcare costs on members (Devers, Casalino, Rudell, et al., 2003; CompCom, 2019).

These networks have become a pivotal element of strategic purchasing, where the bargaining power tied to market share significantly influences price negotiations (Devers et al., 2003; Greer, Klasa & Ginneken, 2020). Greer, Klasa, and Ginneken (2020) argue that critical imbalances in information, market power, political power, and financial power hinder the successful implementation of strategic purchasing, consistently falling short of promises. They suggest future strategies should align expectations with actual effectiveness. Market power in medical schemes, where higher shares enable negotiation influence, is evident; however, conclusive evidence of consistent value across medical disciplines is lacking (Greer, Klasa, & Ginneken, 2020).

Additionally, smaller schemes may face challenges leveraging better rates (CompCom, 2018). The HMI provisional report (CompCom, 2018) emphasises the importance of considering factors beyond cost savings in network formation, noting potential oversight of metrics like patient outcomes. Consumers often lack insight into how funders establish networks (Greer, Klasa, & Ginneken, 2020; CompCom, 2018).

Beyond cost containment, DSPs influence medical treatments by implementing protocols and guidelines. They negotiate with pharmaceutical manufacturers, manage formularies, and promote generic drug utilisation (Howard, Harris, Frank et al., 2018). Evaluating DSP's impact on financial sustainability involves balancing cost containment and maintaining high-quality healthcare services (Greer, Klasa, & Ginneken, 2020; CompCom, 2018). Indicators like the financial performance of medical schemes and healthcare outcomes gauge DSP-driven strategy success, but inconsistent reporting and lack of public availability pose challenges (CompCom, 2019). Involving customers in strategically purchasing designated service contracts is crucial for success and alignment with preferences and needs (Greer, Klasa, & Ginneken, 2020; CompCom, 2018; CompCom, 2019). Despite DSPs' significant role, arguments against their strategies exist, including the lack of conclusive evidence for consistent value across medical disciplines and challenges for smaller players in negotiations (Greer, Klasa, & Ginneken, 2020; M'bouaffou et al., 2022). Critics suggest potential compromises in healthcare quality due to an overemphasis on cost containment (Maphumulo & Bhengu, 2019). The universal realisation of value and challenges in negotiating favourable terms, especially in smaller schemes, raise concerns (Greer, Klasa, & Ginneken, 2020). The absence of consistently reported indicators hampers the accurate assessment of DSP-driven initiatives and limits transparency and accountability in their strategies (OMAC, 2010; Noga, 2014; CompCom, 2019). These arguments underscore the need for careful and balanced consideration of potential drawbacks and challenges associated with DSP strategies in the healthcare industry.

Ensuring the delivery of high-quality healthcare services is paramount, as it profoundly influences patient outcomes, satisfaction, value creation, and cost control (Mosadeghrad, 2014). The author further asserts that healthcare quality can be enhanced through supportive visionary leadership, meticulous planning, education and training initiatives, adequate resource availability, effective management of both human and material resources, as well as streamlined processes (Mosadeghrad, 2014). Additionally, fostering collaboration and cooperation among healthcare providers is pivotal in improving healthcare quality. Promoting collaboration and cooperation among healthcare providers is also pivotal in improving healthcare quality. DSPs play a crucial role in ensuring quality assurance by fostering collaboration and setting standards of care among network providers, utilising technology and data analytics to monitor and enhance healthcare service quality (Walkowska,Przymuszała, Marciniak-Stępak, et al., 2023). DSPs play a crucial role in ensuring quality assurance by fostering collaboration and setting standards of care among network providers, utilising technology and data analytics to monitor and enhance healthcare service quality. Technology, including data analytics and digital platforms, is a central theme, highlighting how DSPs track and analyse healthcare performance indicators, identify areas for improvement, and facilitate real-time feedback (Batko & Ślęzak, 2022).

DSP arrangements have also evolved towards standardising care by implementing evidence-based practices, clinical guidelines, and best practices (CMS, 2008). Provider compliance and accountability are essential components of quality assurance, and the analysis examines how DSPs ensure adherence to established standards and guidelines (CMS, 2008; CMS, 2014; Panteli, Legido-Quigley, Reichebner et al., 2019).

This involves exploring mechanisms for monitoring provider performance, addressing deviations from standards, and fostering a culture of accountability among healthcare providers (Babiker, Husseini, Nemri, et al., 2014). While the emphasis on ensuring high-quality healthcare services through DSPs is widely supported, dissenting voices raised valid concerns. Critics argue that excessive reliance on technology and data analytics, as DSPs advocate, may jeopardise the human-centric aspects of patient care (Raghupathi & Raghupathi, 2014; Batko & Ślęzak, 2022).

9. ANALYSIS AND RESULTS

Descriptive analysis

Examining complaints associated with the DSP revealed two primary categories: complaints about non-payment or underpayment of claims. Notably, underpayment constituted the majority of DSP-related complaints, comprising 88%, while non-payments constituted the remaining 22%. Within the underpayment category, a significant portion—almost half of all DSP-related complaints—was attributed to the short payment of claims, as depicted in Table 1 below.

Table 1: DSP related complaints- 2018

Nature Description	N	%
Non-Payment PMB-Emergency/ CDL/DTP DSP	26	13%
Short Payment Non-PMB DSP	18	9%
Short Payment PMB -Emergency/CDL/DTP DSP	99	48%
Short Payment PMB -Emergency/ CDL/DTP Non- DSP Involuntary	37	18%
Short Payment PMB -Emergency/ CDL/DTP Non-DSP Voluntary	28	13%

More specifically, the short payment category was particularly pronounced in instances involving emergency claims categorised as PMBs and those related to chronic conditions diagnosed and treated during emergencies. These situations accounted for nearly 50% of all DSP-related complaints related to short payments. Further breakdown of the short payment category revealed that claims associated with PMBs and emergency-related diagnoses, where non-DSP options were used involuntarily, contributed to 18% of the complaints. On the other hand, cases where non-DSP options were used voluntarily accounted for 13% of the complaints. Short payments related to non-PMB-related complaints constituted 9% of the overall complaints in this category. The subsequent section of the analysis delves into each thematic area, providing a more granular exploration that stratifies the data to extract insights from subthemes within each category. Notably, the study brings to light a salient observation: complaints related to short payments, particularly those associated with PMB emergency types, represent an emerging issue that warrants focused attention and investigation.

Thematic analysis 1: Non-payment of PMB emergency-related complaints

Table 2 below summarises the thematical analysis of non-payment of PMB emergency repeated complaints. The study showed that members face various challenges and grievances within the scheme, primarily centred on the denial of funding for designated PMB conditions. This includes cases involving Neuropathic Bladder, amputation, and cataract treatment, where members express dissatisfaction with the scheme's failure to settle accounts related to PMBs. The voluntary use of non-DSPs poses another issue, leading to disputes over funding, especially in areas where DSPs are absent. The lack of nearby DSPs further compounds the problem, forcing members to seek treatment at non-DSPs and resulting in funding disputes.

Additionally, denial of emergency PMB treatment due to the non-use of DSPs during emergencies creates further challenges. Co-payments, particularly on chronic medication, contribute to member discontent, with pensioners facing financial burdens and struggling to access affordable alternatives. Disputes over specific medical procedures, such as wound care and ICD 10 code N18.9, highlight the need for clarity and resolution in funding these cases. Communication and information issues exacerbate the situation, with members expressing grievances over a lack of clear communication and awareness of restrictions, leading to unresolved disputes.

Table 2: Non-payment of PMB emergency-related complaints

Theme	Key Insights
Failure to Settle PMB Accounts	- Denial of funding for designated PMB conditions like Neuropathic Bladder, amputation, and cataract treatment.
Voluntary Use of Non-DSP	- Challenges arising from voluntary use of non-DSP facilities leading to funding disputes. - The absence of designated service providers in residential areas forces members to seek treatment outside the DSP network.
Lack of Nearby DSPs	- Inconvenience caused by the absence of Designated Service Providers (DSPs) near members' residences. - Members seeking treatment at non-DSPs due to nearby DSPs' unavailability, resulting in funding disputes.
Emergency PMB Treatment	- Denial of emergency PMB treatment due to non-use of DSPs during emergencies. - Members arguing that the urgent nature of their conditions necessitated immediate treatment, often at non-DSPs, leading to disputes over funding.
Co-payments and Financial Concerns	- Discontent with co-payments imposed by the scheme, especially on chronic medication. - Pensioners were facing financial burdens and difficulties accessing affordable alternatives.
Disputes Over Specific Medical Procedures	- Complaints regarding disputes over specific medical procedures, such as wound care and ICD 10 code N18.9. - Indication of a need for clarity and resolution regarding the funding of these specific cases.
Communication and Information Issues	- Grievances revolving around a lack of clear communication and information the scheme provides. - Members claiming unawareness of certain restrictions, such as non-DSP usage for specific services, leading to disputes and unresolved issues.

Thematic analysis 2: Short payment of Non-PMB, Diagnosis (ICD-10), DSP-related complaints

Discrepancies and conflicts regarding co-payment details have emerged, with alleged non-disclosure of co-payment terms contributing to financial grievances. Introducing unexpected changes in chronic medication funding has added complexity and confusion to the situation. Dissatisfaction is expressed concerning the quality of services provided by designated service providers, coupled with complaints about inadequate feedback and assistance from the scheme. Disputes have arisen over denying funding for medical treatments, accompanied by allegations of improper classification impacting funding decisions. There is a perceived link between involuntary non-DSP usage and funding denials.

Grievances centre around insufficient availability of DSPs, disputes concerning the recognition of doctors listed as DSPs, and claims of a reduction in DSP hospitals leading to challenges in accessing services. Furthermore, there are complaints about a lack of clear communication regarding co-payment terms and allegations of inadequate information concerning DSPs and hospital changes.

Table 3: Short payment of Non-PMB, Diagnosis (ICD-10), DSP related complaints

hematic area	Key Insights and Findings
Financial Disputes and Co-payment Issues	- Discrepancies and disputes over co-payment details. - Alleged non-disclosure of co-payment terms causing financial grievances. - Unexpected changes in chronic medication funding are confusing.
Service Quality and DSP Satisfaction	- Dissatisfaction with the service quality provided by designated service providers. - Complaints about inadequate feedback and assistance from the scheme.
Medical Treatment Funding Denials	- Disputes over denial of funding for medical treatments. - Allegations of improper classification affecting funding decisions. - Perception of involuntary non-DSP usage leading to denials.
DSP Availability and Recognition Issues	- Grievances over inadequate DSP availability. - Disputes regarding the recognition of doctors listed as DSPs. - Alleged reduction in DSP hospitals leading to service accessibility issues.
Communication and Information Concerns	- Complaints about a lack of clear communication on co-payment terms. - Allegations of inadequate information provided regarding DSPs and hospital changes.

Thematic analysis 3: Short payment of PMB-EMERGENCY DSP-rated complaints

The scheme faces serious allegations of misconduct, notably its failure to fund essential PMB-related treatments, raising concerns among members who emphasise the clinical necessity and urgency of such procedures. Disputes have arisen over the scheme's reluctance to settle accounts related to surgeries, admissions, and other medical procedures falling under the PMB category, contributing to dissatisfaction and financial grievances. Members are particularly aggrieved by the alleged involuntary use of non-DSP due to the unavailability of DSPs in close proximity, resulting in disputes over co-payments, especially in emergencies where non-DSP usage is perceived as unavoidable.

Moreover, there are complaints about the scheme's inadequate communication, with members expressing dissatisfaction over the lack of timely and clear information regarding the status of service providers, DSP locations, and changes in hospital affiliations. Additionally, grievances include disputes over recognising doctors listed as DSPs and the perceived reduction in DSP hospitals, impacting accessibility and leading to involuntary non-DSP utilisation. Despite repeated attempts, members have lodged complaints about the scheme's apparent failure to assist and resolve disputes, contributing to dissatisfaction with the quality of feedback and assistance provided in response to various claims and disputes.

Table 4: Short payment of PMB-Emergency DSP-rated complaints

Thematic Area	Key Insights
Denial of Funding for PMB Treatment	- Allegations of improper conduct by the scheme for failing to fund various PMB-related treatments despite members claiming clinical necessity and urgency. - Disputes over short payments and refusal to settle accounts for surgeries, admissions, and procedures deemed as Prescribed Minimum Benefit conditions.
Involuntary Use of Non-DSP and Co-payment Disputes	- Members are expressing grievances over the alleged involuntary use of non-DSP due to the unavailability of DSPs nearby. - Complaints about co-payment disputes, particularly in emergencies, where members argue that non-DSP usage was unavoidable.
Communication and Information Issues	- Complaints about the scheme's failure to provide timely and clear information, especially regarding the status of service providers, DSP locations, and changes in hospital affiliations. - Allegations of improper short payments due to insufficient or outdated information the scheme provides.
Disputes Over DSP Recognition and Availability	- Members expressing dissatisfaction with the scheme's recognition of doctors listed as DSPs and disputes over the reduction of DSP hospitals, impacting accessibility. - Grievances regarding the alleged reduction in DSPs and challenges in locating DSPs within a reasonable distance, leading to involuntary non-DSP use.
Failure to Address Disputes and Provide Assistance	- Complaints about the scheme's failure to assist and resolve disputes, even after repeated attempts by members to address the issues. - Dissatisfaction with the quality of feedback and assistance provided by the scheme in response to various claims and disputes.

Thematic analysis 4: Short payment related to PMB-EMERGENCY/CDL/DTP Non-DSP Involuntary rated complaints

Members are raising multifaceted grievances against the scheme, encompassing allegations of improper conduct and disputes across various themes. They express dissatisfaction with the scheme's failure to fully fund emergency treatments, citing instances where crucial medical attention was needed and DSPs were unavailable. Disputes over short payments and co-payment imposition surface, challenging the scheme's handling of admissions, surgeries, and procedures, especially concerning PMB conditions. Complaints extend to the alleged involuntary use of non-DSPs due to the unavailability of nearby DSPs, resulting in co-payment conflicts. Additionally, members voice concerns about the scheme's communication practices, emphasising a lack of timely and clear information on service providers, DSP locations, and changes in hospital affiliations. The dissatisfaction extends to perceived inefficiencies in the scheme's dispute resolution and assistance mechanisms, with members expressing frustration over the quality of feedback and support in response to various claims and disputes.

Table 5: Short payment related to PMB-EMERGENCY/CDL/DTP Non-DSP Involuntary rated complaints

Thematic Area	Summary of Complaints
Emergency Medical Treatment	Members express grievances over the scheme's refusal to settle accounts for emergency medical treatments, citing the unavailability of DSPs as a reason. They argue that such cases should be fully funded under PMB conditions.
Short Payment Disputes	Complaints arise regarding short payments for various medical services, with members disputing co-payments and challenging the scheme's imposition of additional fees for non-DSP usage. Disputes mainly focus on cases where the chosen benefit options are claimed to cover all admissions, regardless of DSP utilisation.
Non-DSP Usage and Co-payment Disputes	Members face disputes related to the alleged involuntary use of non-DSPs due to the unavailability of DSPs nearby, leading to co-payment conflicts. Grievances involve situations where members contend that non-DSP usage is unavoidable, especially in emergencies, and request the scheme to fund accounts accordingly.
Communication and Information Issues	Dissatisfaction is expressed over the scheme's failure to provide timely and clear information, including details about service providers, DSP locations, changes in hospital affiliations, and reductions in DSPs. Members highlight challenges in locating DSPs within reasonable distances, impacting accessibility and leading to involuntary non-DSP use.
Dispute Resolution and Assistance	Members complain about the scheme's apparent failure to assist and resolve disputes effectively. Despite repeated attempts by members to address issues, there is dissatisfaction with the quality of feedback and assistance provided by the scheme in response to various claims and disputes.

Thematic area 5: Short payment related to PMB-EMERGENCY/CDL/DTP Non-DSP Voluntary related complaints

The complainant expresses grievances with the scheme on various counts. In one instance, the complaint pertains to an alleged short payment for a PMB account when the member underwent hip replacement surgery at Mediclinic Nelspruit, with the scheme contending voluntary use of a non-DSP. Another grievance involves the scheme's failure to settle an account for cataract removal at Johannesburg Eye Hospital, with the complainant disputing the non-DSP usage claim. Additional concerns encompass instances where urgent surgery led to using a non-DSP due to the unavailability of a designated specialist. Complaints also involved disputes over co-payments, involuntary non-DSP usage due to proximity issues, and the scheme's refusal to fund PMB treatments fully. The attached documents provide further details supporting these grievances.

Table 6: Short payment related to PMB-EMERGENCY/CDL/DTP Non-DSP Voluntary related complaints

Thematic Areas	Summary
Short Payment for PMB Accounts	Numerous complaints involve the scheme allegedly short-funding accounts related to PMB conditions, such as hip replacement surgery, cataract removal, emergency eye operations, and urgent vascular surgery.
Non-DSP Usage Disputes	The complainants contest the scheme's claims of voluntary use of non-SP, asserting that they were not adequately informed of DSP options or that DSPs were unavailable within a reasonable radius.
Co-payment Issues	Grievances include instances where the scheme imposed co-payments for using non-DSP providers, and complainants seek refunds or waiver of these co-payments, particularly in emergencies.
Lack of DSP Accessibility	Some complainants cite the unavailability of DSPs in their areas, leading to the involuntary use of non-DSPs due to proximity issues. The schemes' refusal to fully fund treatments in such cases seemed to be a recurring concern.
Communication and Information Errors	Several complaints highlight allegations of improper conduct by the scheme, such as providing incorrect information about DSP specialists, lack of communication regarding DSP status, and rectification errors leading to account shortfalls.

Re-classification and standardisation

A further refinement of the five sub-thematic areas was undertaken to address emerging concerns identify and eliminate duplication or similar sub-themes. The re-classification process was prompted by the need to enhance the precision and clarity of the sub-thematic distinctions. The visual representation below illustrates the standardised re-classification applied to the 173 closed complaints, accounting for a substantial portion of the initially analysed 208 cases.

This re-classification effort aimed to streamline and categorise the diverse complaints more accurately, ensuring that each sub-theme captures distinct issues raised by medical scheme members. Out of the initially analysed 208 complaints, 173 underwent the re-classification process, resulting in a more refined and nuanced categorisation. The graph depicts that approximately two out of every three complaints lodged by medical scheme members were associated with one of the following four prominent sub-thematic areas: Non-DSP Usage Disputes (17%), Short Payment for PMB Accounts (17%), Emergency Medical Treatment (16%), and Non-DSP Usage and Co-payment Disputes (16%).

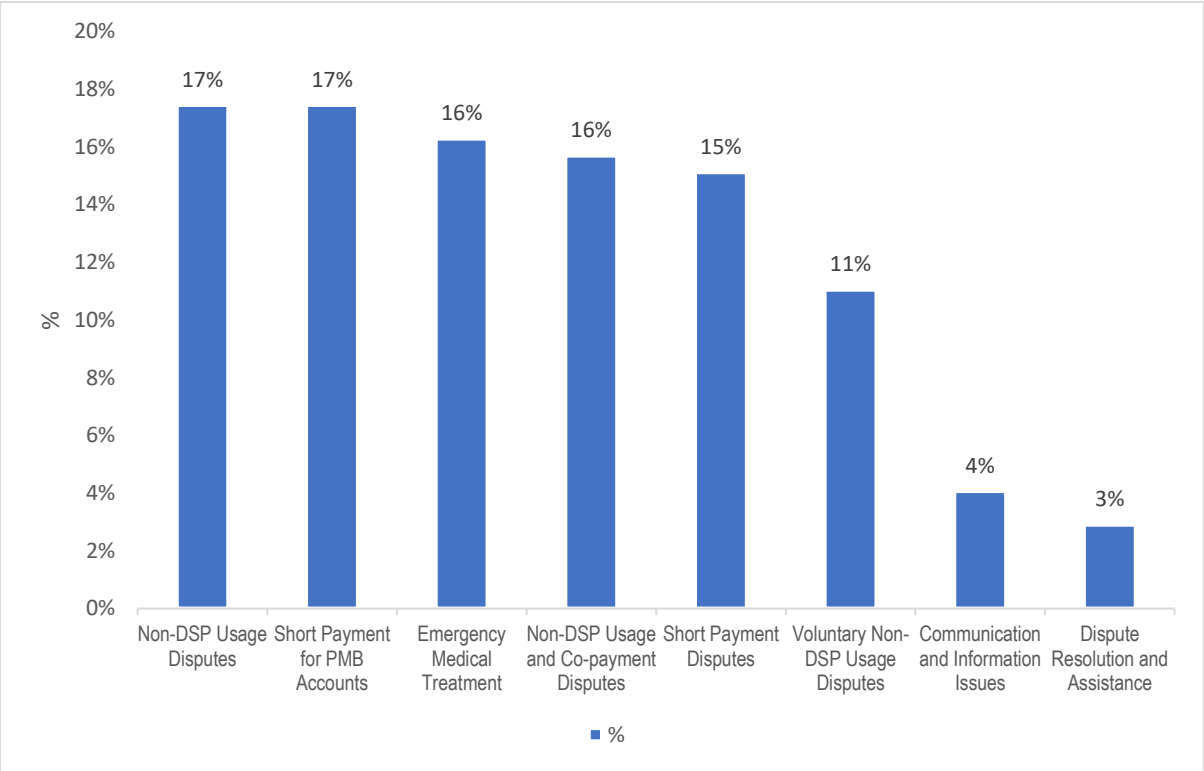

Figure 1: Proportion of valid DSP-related complaints resolved by re-classification category

Number of complaints and resolution time by category by scheme type and size

The table (Table 7) below presents a breakdown of complaint counts based on scheme type, revealing a noteworthy disparity in the distribution of complaints, particularly with a significant majority originating from open schemes. The percentage gap between the two strata is substantial, reaching 65%. However, it's essential to highlight that this gap narrows considerably in disputes related to the voluntary use of non-DSP facilities. There were 13 complaints from closed schemes in this specific category, closely trailing the 17 complaints reported in open schemes. Moreover, the percentage gaps become more pronounced in certain types of complaints. For instance, the Emergency Medical Treatment category exhibits a higher prevalence in open schemes, contributing to the imbalance.

Similarly, Non-DSP Usage and Co-payment Disputes and Voluntary Non-DSP Usage Disputes showed substantial percentage gaps, indicating a notable skew towards open schemes in these specific areas of concern. These observations underscore the importance of considering scheme type when analysing and addressing different complaint categories within the overall scheme operations. When adjusting for the size of schemes, it becomes evident that large schemes played a predominant role, accounting for 159 out of the 172 valid complaints, constituting 92% of the total. In contrast, small schemes contributed 12 complaints, representing 7% of the valid complaints, while medium-sized schemes comprised the remaining 1%.

This distribution highlights the disproportionate impact of large schemes on the overall number of valid complaints. The majority of concerns are concentrated within large schemes, suggesting a need for targeted attention and resolution strategies to address the specific challenges and issues in this category. Understanding the distribution across scheme sizes is crucial for formulating effective interventions and improvements tailored to the unique dynamics of each scheme category.

Table 7: Number of complaints by scheme type

	N			
New category	Closed	Open	Gap ratio	Total
Communication and Information Issues	1	6	83%	7
Dispute Resolution and Assistance	2	3	33%	5
Emergency Medical Treatment	4	24	83%	28
Non-DSP Usage and Co-payment Disputes	5	22	77%	27
Non-DSP Usage Disputes	9	21	57%	30
Short Payment Disputes	7	19	63%	26
Short Payment for PMB Accounts	13	17	24%	30
Voluntary Non-DSP Usage Disputes	4	15	73%	19
Total	45	127	65%	172

Average time to resolve complaints by category and scheme type

The average duration for resolving complaints related to communication and information issues, Non-DSP payment disputes, and dispute resolution and assistance was notably extended in closed schemes. Conversely, in other categories, the longer time required for resolution was observed in open schemes. The prolonged resolution time for complaints falling under the Emergency Medical Treatment category is particularly significant. These complaints took 147 days to resolve in open schemes and 188 days in closed schemes. This extended timeframe has had the potential to adversely impact members' access to timely care and may have long-term consequences on their health status. The risk of deterioration or increased severity of health conditions during the prolonged resolution period could lead to more complex and costly hospitalisations. This underscores the urgency of addressing and expediting the resolution process, especially in critical categories like Emergency Medical Treatment, to ensure the well-being and satisfaction of scheme members.

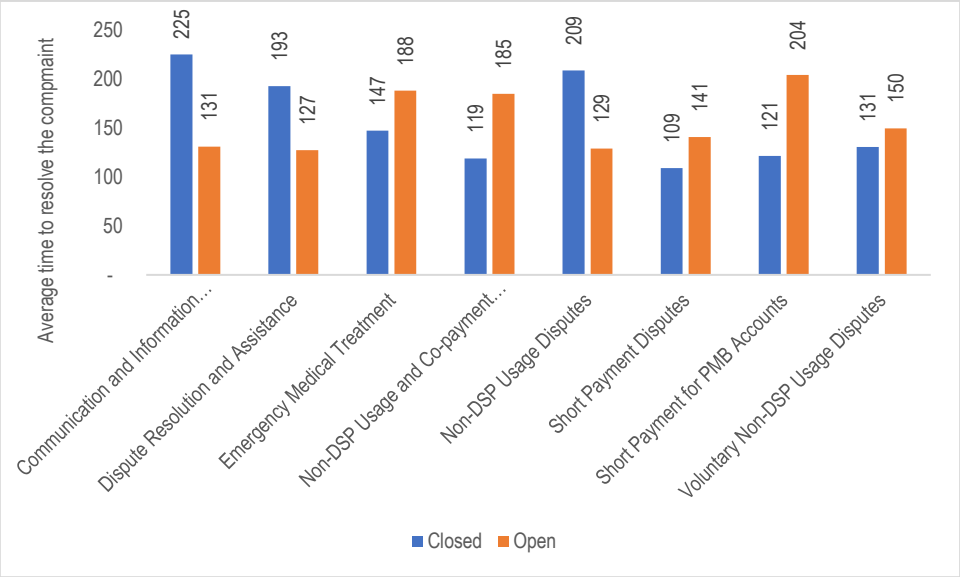

Figure 2*:* Average resolution time of complaints by complaint type and scheme type

Survival analysis

A survival analysis was executed to evaluate the duration until failure, and the corresponding Kaplan-Meier curves are illustrated in the figure below. Additionally, the analysis includes the depiction of incidence rates and survival times. The median survival times were observed to be comparatively shorter for categories such as Dispute Resolution and Assistance and Short Payment Disputes, recording median survival times of 78 days (IQR 77-225) and 75 (IQR 39-202), respectively. This implies a relatively swift resolution or closure for cases falling under these specific categories. In contrast, the median survival time for Emergency Medical Treatment was 158 days (IQR 60-261), suggesting a more extended duration for resolving emergency medical care issues.

Table 8: Incidence rates and survival times by complaints category

newcat~y	time at risk	incidence rate	no. of subjects	Survival time 25%	50%	75%
Communic	1012	.006917	7	77	129	225
Dispute	768	.0065104	5	36	78	277
Emergenc	5107	.0054827	28	60	158	261
Non-DSP	4588	.0065388	30	66	99	223
Non-DSP	4667	.0057853	27	58	169	245
Short Pa	3439	.0075603	26	39	75	202
Short Pa	5055	.0059347	30	34	107	237
Voluntar	2767	.0068666	19	69	118	209
total	27403	.0062767	172	51	117	237

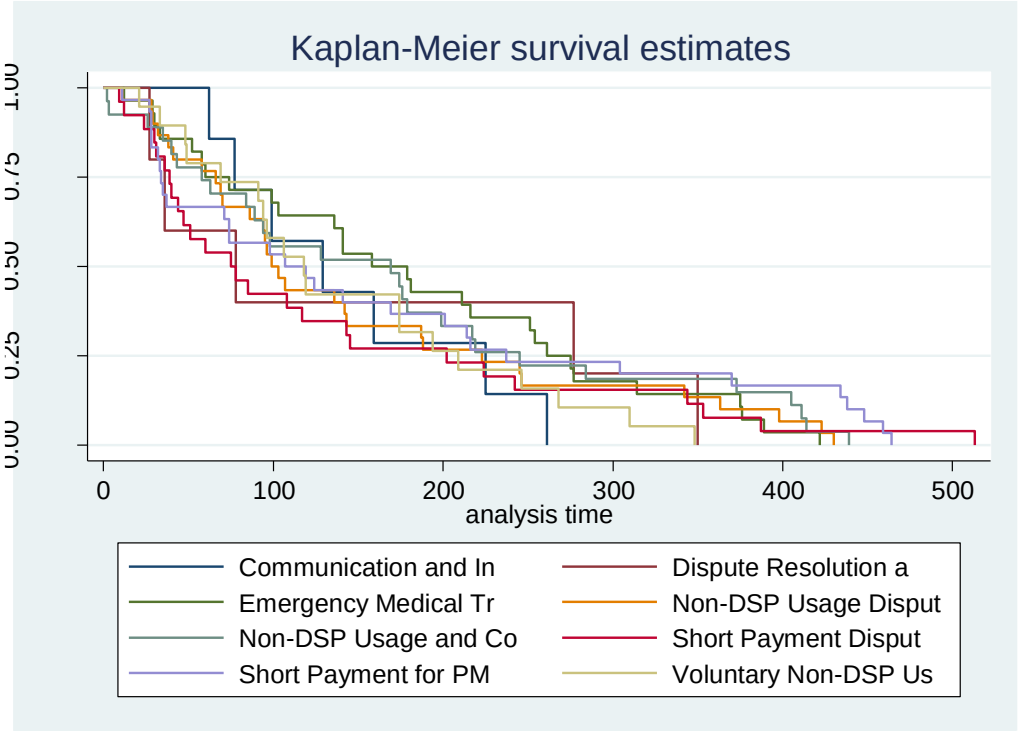

Figure 3: Kaplan -Meier survival estimates

10. DISCUSSION

Examining medical scheme complaints regarding the DSP uncovers complex and varying permutations primarily marked by problems of non-payment and underpayment. Complaints concerning non-payment involving the refusal to provide funds for PMB requirements were one of the notable categories. These findings align with previous research; for instance, the CMS annual report of 2019, as referenced in Mngadi et al. (2019), illustrated a substantial surge of nearly three times in the volume of complaints related to PMBs. Several CMS reports and a recent study by Nkomo foundd non-compliance by medical aid schemes regarding payment for PMBs (CMS, 2009; Nkomo, 2023). The regulatory framework concerning the PMB Code of Conduct was last issued in 2010 and subsequently in 2017, despite the evolving healthcare environment (CMS, 2010, 2017). The other limitation is the enforceability of the code of good conduct and guidelines—persistent non-compliance to paying PMBs in full affects members, leading to increased out-of-pocket payments. The financial stress experienced by members is exacerbated by their dissatisfaction with co-payments, particularly for chronic medicine. The study also found co-payments related to Non-DSPs, where nearly one in five complaints were related to this category. The Medical Schemes Act permits medical schemes to impose a co-payment; for example, members are obligated to obtain their healthcare services from the DSPs listed in their scheme's rules (CMS, 2008). If a member voluntarily decides to use a non-DSP, they become liable for a co-payment or deductible specified in the rules of your scheme (CMS, 2008).

Furthermore, if members obtain a service from a non-DSP involuntarily, and it's a PMB condition, the scheme must pay full costs for your treatment, diagnosis and care (CMS, 2008). Generally, complaints related to non-DSP use (including those unrelated to co-payment disputes) accounted for a third of all the complaints analysed. However, persistent health literacy challenges and the intricate nature of medical scheme benefits contribute to information asymmetry issues. This study identified an insignificant proportion of DSP communication and information problems complaints.

Financial conflicts escalate due to the refusal of emergency PMB treatment, leading members to seek care at non-designated service providers urgently. Tiwary, Rimal, Paudyal, et al. (2019) assert that conflicts regarding particular medical interventions and deficiencies in communication play a substantial role in the overall dissatisfaction of members. Research has additionally established a connection with information asymmetry in this context. For instance, Mngadi et al. (2019) discovered in their study that an equal number of judgments on emergency conditions favoured members and schemes, emphasising the ongoing contention and confusion in this matter. Regrettably, from the members' standpoint, when they perceive a medical condition as an emergency, they are prone to seek assistance from the nearest healthcare provider without verifying whether it is a DSP (OMAC, 2010; Noga, 2014). Within a larger framework, DSPs influence the financial environment and bargaining conditions with healthcare providers. Nevertheless, there are ongoing questions regarding the overall efficacy of DSP tactics, especially regarding smaller schemes (OMAC, 2010; Noga, 2014; CompCom, 2019; Mngadi, et al., 2019; Greer, Klasa, & Ginneken, 2020).

11. CONCLUSION

Reinforcing communication strategies, broadening the Designated Service Provider network, streamlining emergency processes, reassessing co-payment policies, and refining PMB review procedures collectively constitute a holistic approach aimed at fostering a healthcare system that is more responsive and centered around the needs of its members. To ensure that members are well-informed about the availability and benefits of DSPs, healthcare entities can strengthen communication channels. Expanding the network of such providers not only increases accessibility for members but also enhances the overall efficiency of healthcare delivery. The optimisation of emergency processes is pivotal in ensuring that members receive prompt and efficient treatment without subsequent disputes over funding. A comprehensive review of co-payment policies, particularly with a focus on addressing financial concerns for vulnerable groups like pensioners, contributes to member satisfaction and financial well-being. Additionally, enhancing PMB review procedures involves implementing a robust process to evaluate critical medical conditions promptly, ensuring timely funding and appropriate care for members. This multifaceted approach, guided by these strategic measures, underscores a commitment to building a healthcare system that prioritises member needs, aligns with evolving healthcare landscapes, and strives for continuous improvement in the quality and responsiveness of healthcare services.

12. FUTURE RESEARCH DIRECTIONS

Future studies should explore the resolution time of complaints, especially in critical categories like Emergency Medical Treatment. This may involve examining the efficiency of dispute resolution mechanisms and their impact on members' access to timely care. Survival analysis, focusing on the duration until failure and the corresponding Kaplan-Meier curves, provides valuable insights into the temporal aspects of complaint resolution. Future research could explore the underlying factors contributing to shorter or prolonged resolution times, considering variables such as scheme size and type.

The study touches upon the complexities related to non-payment and underpayment issues, especially concerning PMBs. Future research could further investigate the regulatory framework, exploring the effectiveness and enforceability of the PMB Code of Conduct, last published in 2010 and reviewed in 2017. Understanding the reasons behind persistent non-compliance and its impact on members' out-of-pocket payments can guide policy interventions. An exploration of the evolving role of DSPs, particularly their impact on financial environments and bargaining conditions with healthcare providers, can be extended. Research could delve into questions surrounding the overall efficacy of DSP tactics, especially in smaller schemes. The proposed recommendations highlight the importance of strengthening communication channels, expanding DSP networks, streamlining emergency processes, reassessing co-payment policies, and refining PMB review procedures. Lastly, future research could assess the implementation and effectiveness of these recommendations, providing insights into their impact on member satisfaction, financial well-being, and overall healthcare system responsiveness.

13. RECOMMENDATIONS

Building upon the analysis and findings derived from the study, a set of recommendations is proposed for medical schemes, extending their relevance to encompass medical service providers and the scheme's members. It is asserted that all stakeholders in the healthcare value ecosystem possess the potential to contribute collectively to an enriched understanding of strategic purchasing and the identified gaps associated with DSPs. This collaborative method aims to promote a thorough and inclusive viewpoint, bringing together medical schemes, service providers, and members to work towards the shared objective of improving strategic purchasing in healthcare. To better understand the difficulties linked to DSP, it is important to engage with all stakeholders in the ecosystem. This will allow for creating specific solutions and a mutually beneficial partnership that benefits the whole healthcare value chain.

- Strengthening communication channels is paramount to ensuring members are well-informed about the availability of DSPs. Clear communication should extend to articulating the limitations associated with non-DSP usage, providing members with comprehensive information on potential co-payments. This proactive approach fosters transparency, empowering members to make informed decisions about their healthcare choices.

- To offer members more accessible options for healthcare services, it is recommended to explore opportunities for expanding the network of DSPs. By minimising reliance on non-DSPs and creating a comprehensive, convenient network, the aim is to enhance member satisfaction and promote a seamless healthcare experience. This expansion should be strategic, considering geographical coverage and the diverse healthcare needs of the membership.
- Developing and implementing streamlined processes for emergencies is crucial. This ensures that members receive prompt treatment without subsequent disputes over funding. Prioritising efficient and effective procedures to handle urgent medical needs maintains adherence to guidelines while addressing potential bottlenecks in emergency care. Optimisation in this area contributes to both member satisfaction and positive health outcomes.
- Conducting a comprehensive evaluation of co-payment policies, specifically addressing financial concerns, is imperative. This is particularly important for vulnerable groups such as pensioners. The aim is to create policies that adhere to regulatory standards and enhance member satisfaction by alleviating financial burdens associated with co-payments. This review should consider the socioeconomic diversity within the membership.
- Implementing a robust review process for PMB-related claims is essential to prevent unnecessary disputes. A thorough and timely assessment of critical medical conditions is crucial, facilitating prompt funding and ensuring appropriate care for members. This recommendation underscores the importance of meticulous oversight in reviewing PMB-related claims to uphold the highest standards of healthcare delivery within medical schemes.

Author contributors

Michael Mncedisi Willie (MMW) drafted the concept, conducted data preparation and analysis. Stephen Monamodi (SM) edited and proofread the report..

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Ethical consideration

The study did not involve accessing or disclosing participants' personal or clinical data, nor did it directly involve the treatment of patients. The data were evaluated and reported only at an aggregated level to ensure privacy and confidentiality.

Declaration of interests

The author states that there are no financial or personal affiliations that could have unduly influenced the content of this article.

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