



# SAPPF CONFERENCE 2026

INFORM. EMPOWER. SUCCEED.

Essential Ingredients for Private Practice



6-7 June 2026



Johannesburg Marriott  
Hotel Melrose Arch

MEMBER INSIGHTS AND CONFERENCE REPORT



## ABOUT THIS BOOKLET

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The SAPPF Conference 2026 brought healthcare professionals, industry leaders, policymakers, funders and strategic partners together for two days of focused discussion on the future of private healthcare in South Africa.

This booklet records the central themes, insights and practical considerations arising from the conference. It has been prepared as a resource for SAPPF members and is intended to support continued discussion, informed decision-making and constructive engagement across the private healthcare sector.



The content reflects the presentations and panel discussions held during the conference. It should not be interpreted as legal, financial or clinical advice. Members should seek appropriate professional advice where necessary.

## PUBLICATION DETAILS

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## SAPPF CONFERENCE 2026

# Introduction

The South African Private Practitioners Forum Conference 2026 brought healthcare professionals, industry leaders, policymakers, funders and strategic partners together for two days of focused discussion on the future of private healthcare in South Africa.

Representing a network of more than 5,000 healthcare professionals across 13 disciplines, SAPPF created a platform for honest dialogue, practical learning and meaningful collaboration. The conference explored the regulatory, financial, technological and operational forces shaping private practice, while identifying workable solutions to strengthen its sustainability.

## A STRATEGIC PLATFORM FOR PRIVATE PRACTICE

Private healthcare operates in an increasingly complex environment. Changing legislation, evolving reimbursement models, rising practice costs, data and coding requirements, medicolegal risk and rapid technological development all influence how healthcare professionals practise and serve their patients.

The SAPPF Conference addressed these realities directly, equipping delegates with credible insights, practical tools and access to decision-makers who are helping shape the future of the sector.

## PROGRAMME HIGHLIGHTS

The two-day programme included expert presentations, moderated panel discussions and opportunities for professional engagement. Key areas of focus included:

|                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>01</b>   <b>The future of healthcare policy</b></p>  <p>The SAPPF legal challenge relating to the National Health Insurance Act and the broader implications of healthcare reform.</p>                      | <p><b>02</b>   <b>Value-based care</b></p>  <p>Alternative reimbursement models, regulation, coding challenges and the role of healthcare professionals in value-based systems.</p>            | <p><b>03</b>   <b>Sustainable practice models</b></p>  <p>Solo and group practice structures, multidisciplinary teams, practitioner employment and the financial sustainability of different operating models.</p> |
| <p><b>04</b>   <b>Data-driven healthcare</b></p>  <p>Access to healthcare data, interoperability, appropriate coding, artificial intelligence and the development of stronger healthcare information systems.</p> | <p><b>05</b>   <b>Financing healthcare</b></p>  <p>Medical scheme reimbursement, affordability, gap cover, cost containment, innovation and the balance between access and sustainability.</p> | <p><b>06</b>   <b>Legal and professional risk</b></p>  <p>POPIA, PAIA, Section 59 of the Medical Schemes Act, professional indemnity, cybersecurity and patient-record management.</p>                             |

The programme also addressed the medicolegal implications of social media and included a dedicated networking evening for delegates and industry stakeholders.

## WHO ATTENDED?

### CLINICAL & HEALTHCARE PROFESSIONALS

Private healthcare practitioners

Professional medical associations and societies

Healthcare funders and medical schemes

Hospital groups and healthcare administrators

### INDUSTRY & STRATEGIC PARTNERS

Regulatory, legal and policy specialists

Health technology, data and coding organisations

Professional indemnity and risk-management providers

Strategic partners supporting private healthcare



## THE SAPPF COMMITMENT

SAPPF remains committed to championing sustainable private practice, professional excellence and ethical healthcare delivery.

The conference reinforced the importance of bringing all stakeholders to the table and creating space to learn, debate, challenge established thinking and move forward with shared purpose.

Through informed discussion, practical insight and constructive collaboration, the SAPPF Conference 2026 helped healthcare professionals and industry partners remain:

**INFORMED. EMPOWERED. SUCCESSFUL**

## KEYNOTE

# SAPPF NHI Legal Challenge: The Road Ahead

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**DATE:** 6 June 2026

**SPEAKERS:** Dr Simon Strachan and Martin Versfeld

## EXECUTIVE SUMMARY

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This session provided SAPPF members and conference delegates with a strategic update on SAPPF's legal challenge to the National Health Insurance Act and the implications for private practice. Dr Simon Strachan explained that SAPPF's challenge was instituted because the organisation believes the NHI Act is unimplementable, unaffordable, unconstitutional, irrational, dangerous for healthcare delivery and access, and threatening to private practice. He also emphasised that SAPPF believes private specialists and private practitioners have not been adequately heard despite many years of participation in the legislative process.

Martin Versfeld positioned the litigation as both a legal and strategic process. He explained that the court challenge is not only about obtaining a final judgment, but also about ensuring that SAPPF remains "around the table" in future health reform discussions. He argued that continued pressure is necessary to create meaningful engagement and to avoid superficial solutions that do not address the Act's deeper structural problems.

A key conclusion was that success may take several forms. A final court victory would be significant, but Martin Versfeld also described a successful public participation challenge (which has been brought by the Western Cape Government and BUSA) that sends the Act back to Parliament as an "absolute win", because it could create space for a proper conversation and a broader reconsideration of national health reform. The speakers agreed that SAPPF must continue both its legal action and its policy engagement through initiatives such as UHAC and consensus-building processes.

The speakers acknowledged the complexity and cost of litigation, but argued that the cost of withdrawal, legally, reputationally and strategically, would be greater. The broader message was that SAPPF's position should not be understood as opposition to health reform, but as a principled effort to secure workable, equitable and sustainable healthcare reform for South Africa.



## KEY THEMES & INSIGHTS

### Independent representation

SAPPF's interests are not identical to those of funders, hospitals or other litigants, making its own legal and policy voice essential.

### Litigation as strategy

The legal challenge is a way to maintain pressure, preserve influence and create space for serious engagement.

### A possible return to parliament

Sending the Act back to Parliament could be a major opportunity if SAPPF is ready to engage constructively.

### Risks of withdrawal

Withdrawal would carry legal, reputational and strategic risks and could exclude SAPPF from future policy discussions.

### Reform must continue

UHAC and consensus-building processes are important because SAPPF must offer workable alternatives, not only objections.

### Future workforce concerns

The uncertainty around NHI affects young doctors, specialist supply, practice succession and long-term confidence in private practice.

## PRACTICAL TAKEAWAYS

### 01

#### Stay the Course

SAPPF should continue its legal challenge and avoid withdrawal unless circumstances fundamentally change. It should maintain its independent legal standing rather than relying on other stakeholders to represent private practitioners' interests.

### 02

#### Prepare for Parliament

SAPPF should prepare for the possibility that the Act may be returned to Parliament and should be ready to participate constructively in any renewed process. Members should familiarise themselves with UHAC materials and policy briefs so that SAPPF's reform proposals can be communicated more widely.

### 03

#### Explain & Advocate

Private practitioners should help explain the purpose of the legal challenge to colleagues who remain disengaged. Public messaging should make clear that SAPPF supports accessible, affordable and quality healthcare, while opposing legislation it regards as unworkable.

### 04

#### Publish & Lead

SAPPF and its members should continue publishing and circulating thoughtful commentary on the private sector's role in universal healthcare access. Members should also act as ambassadors to encourage broader professional participation and support.

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

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- SAPPF should continue its legal challenge and avoid withdrawal unless circumstances fundamentally change. It should maintain its independent legal standing rather than relying on other stakeholders to represent private practitioners' interests.
- SAPPF should prepare for the possibility that the Act may be returned to Parliament and should be ready to participate constructively in any renewed process. Members should familiarise themselves with UHAC materials and policy briefs so that SAPPF's reform proposals can be communicated more widely.
- Private practitioners should help explain the purpose of the legal challenge to colleagues who remain disengaged. Public messaging should make clear that SAPPF supports accessible, affordable and quality healthcare, while opposing legislation it regards as unworkable.
- SAPPF and its members should continue publishing and circulating thoughtful commentary on the private sector's role in universal healthcare access. Members should also act as ambassadors to encourage broader professional participation and support.

## QUOTATIONS

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*"If you're not around the table, you're on the table."*

— Martin Versfeld

*"We need to be around the table, and that's where we're minded to stay."*

— Martin Versfeld

*"The threat is not 15 years from now. The threat is right now."*

— Dr Simon Strachan, referring to a point often made by Dr Philip Matley

*"Be careful what we ask for, because if you ask for something and you get it and you're not ready to deal with it, then you're on the back foot."*

— Dr Simon Strachan

## SESSION 1

# Value Based Care: The Health Care Provider Perspective

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**DATE:** 6 June 2026

**MODERATOR:** Dr Eugene Allers

**SPEAKERS:** Darren Sweidan; Dr Katlego Mothudi; Barry Childs; Dr Claude Ndlovu; Dr Carla von Benecke

## EXECUTIVE SUMMARY

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The session examined value-based care as a proposed response to rising healthcare costs, variable quality measurement, and the limitations of volume-driven healthcare delivery. Dr Eugene Allers framed the discussion by noting that value-based care is being adopted internationally but emphasised that South Africa cannot simply import models from other jurisdictions. The South African private healthcare context requires active involvement by practitioners, professional societies, funders, administrators, regulators and other stakeholders.

A central theme was that value-based care must balance cost and quality when assessing patient centred outcomes, rather than reducing the debate to either cost containment or clinical excellence alone. Barry Childs argued that the private sector is already geared towards quality in many respects but faces a long-standing affordability crisis. Katlego Mothudi highlighted implementation complexity, risk adjustment, social determinants of health, and the need to define whether value-based care is primarily a reimbursement model, a delivery model, or both. Claude Ndlovu placed emphasis on system redesign, trust, care coordination, aligned incentives and iterative implementation.

The overall tone was constructive but candid. Speakers acknowledged mistrust between practitioners and funders, the administrative and data burdens associated with new models, and the risk that value-based care could become a rebranded form of managed care or cost control if not properly designed. At the same time, there was broad agreement that doctors must help lead the development of clinical pathways, meaningful outcomes, data systems and reimbursement models.

The session concluded that value-based care is not a quick switch or a single model. It must be co-created, clinically credible, transparent, properly measured, and adapted to local conditions. The most practical examples discussed included Discovery Health's broader work on alternative reimbursement and Medscheme's early OrthoCare model, which prioritises structured conservative care for selected spinal conditions.

## KEY THEMES & INSIGHTS

### Value as a balance between outcomes and cost

Speakers repeatedly returned to the idea that value cannot be assessed through quality alone or cost alone. Barry Childs stressed that cost remains central because the private healthcare sector faces a long-standing affordability challenge. The implication is that sustainability must be considered alongside clinical quality.

### Provider leadership is essential

A strong theme was that funders cannot design better clinical delivery models in isolation because they are not delivering care at the bedside. Doctors and professional societies need to generate the clinical pathways, care redesign and innovation required for meaningful value-based care.

### Trust and collaboration are prerequisites

Claude Ndlovu and Dr Eugene Allers both highlighted mistrust in the system. Value-based care requires explicit agreement on outcomes, shared data, transparent measurement and relationships strong enough to support risk-sharing and iterative improvement.

### Data, measurement and risk adjustment are central

Measurement was presented as both essential and difficult. Speakers noted that providers need access to data, must understand how measurement systems work, and need fair risk adjustment where outcomes are influenced by factors beyond clinical care.

### Value-based care is complex and iterative

Katlego Mothudi warned that value-based care does not lend itself to linear planning. Carla von Benecke similarly described value-based healthcare as something built over time, not switched on overnight.

### Practical implementation requires early and appropriate intervention

Medscheme's OrthoCare example showed how a model can start with a specific clinical area, prioritise conservative care where evidence supports it, and measure outcomes. However, the example also showed that intervention at pre-authorisation stage may be too late to redirect care meaningfully.

## ADDITIONAL INSIGHTS RAISED DURING THE DISCUSSION

|                                                                                                                               |                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ◆ <i>Value-based care must not become a euphemism for managed care or cost containment.</i>                                   | ◆ <i>The South African system requires a locally appropriate model rather than a direct import from other countries.</i>                                         |
| ◆ <i>Practitioners have often felt excluded from policy and regulatory discussions and must be included in future design.</i> | ◆ <i>Trust between funders, practitioners, patients and other stakeholders is a core requirement.</i>                                                            |
| ◆ <i>Cost is a legitimate part of the value equation, but it cannot be the only measure.</i>                                  | ◆ <i>Data transparency and access to relevant information are essential if providers are expected to carry risk or participate in alternative reimbursement.</i> |
| ◆ <i>Social determinants of health complicate outcome measurement and must be considered in risk adjustment.</i>              | ◆ <i>Value-based care requires change management, not only technical design.</i>                                                                                 |
| ◆ <i>Doctors must be central to clinical pathway design.</i>                                                                  | ◆ <i>Early-stage models should be tested, refined and improved over time.</i>                                                                                    |

## KEY QUESTIONS & RESPONSES

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**Q Is value-based care at risk of failing because of high administrative costs, data collection costs, limited savings and limited evidence of improved outcomes?**

*The panel acknowledged that implementation costs can be considerable, particularly for practitioners whose practices may have limited administrative infrastructure. Moving from fee-for-service to value-based care requires new systems, better data collection, closer alignment with funders and more sophisticated measurement. Speakers also noted that value creation may be limited if practitioners are judged on outcomes influenced by social determinants of health beyond their direct control. The response was that programme design is critical: objectives, dependencies, measurement methods, data sharing, risk adjustment and expected outcomes must be agreed upfront. Upfront investment may be necessary, but it should be finite, transparent and linked to measurable results.*

**Q Should South Africa be cautious about importing value-based care models from countries such as the United States?**

*Yes. The panel cautioned against direct comparisons with other health systems. South Africa's private healthcare sector has a different scale, structure and context. Value-based care should not be treated as a single binary model that either succeeds or fails. Instead, it includes a range of alternative reimbursement, quality, risk-sharing and care-coordination approaches. South African models should be locally designed and assessed according to their specific objectives, implementation conditions and stakeholder roles.*

**Q How can doctors and professional societies be involved early enough in the design of value-based care models?**

*Concerns were raised that models are sometimes presented to clinicians after they have already been designed. The emerging answer was that value-based care must be collaborative, with clinicians involved in defining value, designing pathways, identifying outcomes, interpreting data and testing models before implementation.*

**Q How should any value created through these models, be shared?**

*The panel indicated that value-based care will not work unless value is shared fairly with doctors and other participants. Programmes must recognise the contribution of the medical profession and avoid models where savings accrue only to funders while providers carry risk, cost or administrative burden.*

## PRACTICAL TAKEAWAYS

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>01</b></p> <p><b>For private healthcare practitioners</b></p> <p>Practitioners should become actively involved in defining clinical pathways, outcomes and data requirements in their disciplines. Waiting for funders or administrators to design models may leave doctors with imposed systems that do not reflect clinical realities. Practices may also need to build administrative and data capacity over time.</p> | <p><b>02</b></p> <p><b>For SAPPF members and professional societies</b></p> <p>Societies should organise themselves to engage funders on a more equal footing. This includes developing technical expertise, understanding data and risk adjustment, and creating structures that allow collective input into care pathways and reimbursement models.</p> |
| <p><b>03</b></p> <p><b>For healthcare stakeholders</b></p> <p>Funders, administrators and policymakers should avoid designing value-based care without provider input. Models must be transparent, clinically grounded, locally appropriate and capable of sharing value fairly.</p>                                                                                                                                            | <p><i>“Value-based healthcare isn’t a switch. You don’t switch it on overnight. It’s something you build over time.”</i></p>                                                                                                                                                                                                                              |

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

- Ensure practitioners and professional societies are represented in regulatory and policy discussions on value-based care.
- Build provider-side organisational capacity to engage funders, administrators and policymakers.
- Develop discipline-specific clinical pathways led by clinicians.
- Establish transparent data-sharing arrangements between funders and providers.
- Invest in provider understanding of data, measurement and risk adjustment.
- Avoid treating crude cost metrics, length of stay or admission rates as adequate measures of value without clinical context.
- Ensure any risk transfer to providers is accompanied by access to relevant data and appropriate control over care pathways.
- Co-create value-based care models with clear outcomes, dependencies, reimbursement principles and review mechanisms.
- Recognise that social determinants of health affect outcomes and must be reflected in model design.
- Test models incrementally and refine them through ongoing stakeholder engagement.
- Consider early intervention points in care pathways, rather than relying only on late-stage pre-authorisation interventions.

## QUOTATIONS

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*“When you look at things through a value lens, it changes things.”*

*“Value-based care does not lend itself to linear planning, and it’s not easily scalable.”*

*“It’s not necessarily about just incentives, but it’s more a system conversation.”*

*“You can’t manage what you can’t see.”*

*“Value-based healthcare isn’t a switch. You don’t switch it on overnight. It’s something you build over time.”*

## SESSION 2

# Sustainable Practice Models – Changing the mindset | Solo vs Group Pros & Cons

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**DATE:** 6 June 2026

**MODERATOR:** Dr Philip Matley

**SPEAKERS:** Dr Karisha Quarrie; Dr Rajesh Patel; Prof Chris Joseph; Prof Ashraf Coovadia; Dr Sue Tager; Dr Evangelo Apostoleris; Dr Eugene Allers

## EXECUTIVE SUMMARY

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The session examined how private healthcare practitioners can adapt their practice models to remain clinically effective, financially sustainable and relevant in a changing healthcare environment.

Dr Philip Matley framed the discussion around several linked issues: the movement from solo practice towards group and multidisciplinary practice; the regulatory and billing environment; the distinction between multidisciplinary practices and multidisciplinary teams; possible models for doctor employment or contracting; and the role of the private sector in specialist and subspecialist training.

A central theme was that sustainability requires a mindset shift from isolated, individual practice towards structured collaboration, data-driven care, sound governance and stronger engagement with funders. Group practice was presented as offering economies of scale, better leave and call arrangements, peer review, access to stronger IT systems, improved data collection and potential leverage in funder negotiations. At the same time, speakers acknowledged that group practice brings challenges, including loss of autonomy, leadership complexity, income-sharing concerns and the need for carefully managed relationships.

The discussion was practical and candid. Speakers shared real-world models from surgical group practice, mental healthcare, oncology MDTs, hospital governance and academic training. The tone was constructive but realistic: panellists repeatedly emphasised that new models require legal clarity, contractual discipline, ethical governance, professional leadership, data measurement and collaboration between practitioners, hospitals, funders, universities and regulators.

The strongest conclusions were that no single practice model will suit every context; data and outcomes measurement are essential to sustainable practice; multidisciplinary collaboration must be properly structured and, where appropriate, remunerated; and the availability of private-sector participation in training of public sector colleagues is increasingly necessary. The session closed with strong emphasis on building additional training capacity rather than merely shifting existing public-sector resources into private settings.

## KEY THEMES & INSIGHTS

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### **Moving beyond traditional solo practice**

The session repeatedly questioned whether traditional solo practice remains sufficient for the future. While solo practice may remain a starting point for some practitioners, the discussion suggested that the pressures of administration, data collection, funder engagement, training and care coordination increasingly favour group or multidisciplinary structures.

### **Group practice as a platform for sustainability**

Dr Matley described group practice as a structure that can improve efficiency, create better on-call and leave arrangements, reduce isolation and enable stronger peer review. He also stressed that these benefits depend on careful legal and financial planning, compatible relationships and agreed rules on income, expenses, leadership, patient ownership and dispute resolution.

### **Data as the basis for value and negotiation**

A recurring message was that outcomes data changes the relationship with funders. Dr Matley gave the example of a surgical group that embedded outcomes measurement into billing and discharge processes, allowing it to use morbidity, mortality, length-of-stay and readmission data in funder negotiations. Dr Apostoleris similarly emphasised that data is necessary before practitioners can engage seriously in value-based care.

### **Multidisciplinary practice and centres of excellence**

Dr Patel argued that multidisciplinary practice can support better coordinated care and centres of excellence, especially where multiple specialties collaborate around high-volume or complex areas of care. However, regulatory and billing clarity remain important, particularly given the role of the HPCSA ethical framework, PCNS identification and medical scheme billing rules.

### **Multidisciplinary teams require recognition**

The oncology MDT example showed that multidisciplinary teamwork can improve care by ensuring appropriate investigations, reducing unnecessary interventions and coordinating treatment. However, the discussion also highlighted that MDT participation consumes professional time and may need dedicated remuneration rather than being absorbed into routine clinical billing.

### **Employment and contracting of doctors**

Dr Quarrie's contribution highlighted that doctor employment, or structured contracting is likely to become more relevant. The session recognised both potential benefits and risks, including leave, lifestyle, liability, performance management, professional independence and the unresolved question of who funds employment models.

### **Training as a sustainability issue**

The private sector's role in training was framed not as a secondary issue but as central to the future of healthcare. Dr Tager warned that without well-trained doctors, the healthcare system cannot function, irrespective of improvements in AI, value-based care or practice models.

## ADDITIONAL INSIGHTS RAISED DURING THE DISCUSSION

|                                                                                                                          |                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| ◆ Sustainable practice requires practitioners to understand both clinical outcomes and business performance.             | ◆ Group practice can provide economies of scale but requires careful attention to governance, personalities, money and dispute resolution.           |
| ◆ Multidisciplinary teams and multidisciplinary practices are not the same and should not be treated as interchangeable. | ◆ Clinical audit and outcomes data are essential if practices want to demonstrate value and negotiate credibly with funders.                         |
| ◆ Contractual arrangements are central to making multidisciplinary practice workable.                                    | ◆ Medical schemes may need to recognise and remunerate structured MDT participation.                                                                 |
| ◆ Doctor employment may become more common, but it must be ethically designed and fairly funded.                         | ◆ The private sector can help expand training capacity, but additional posts should be created rather than removing capacity from the public sector. |
| ◆ Business training for doctors is inadequate, despite many doctors ultimately needing to run practices.                 | ◆ Private-sector training should be linked to university accreditation, governance and quality oversight.                                            |

## KEY QUESTIONS & RESPONSES

### Q Are group practices and multidisciplinary practices really necessary for the future of private practice?

*The session suggested that they are increasingly important, although not necessarily suitable in the same form for every discipline or setting. Group practice can support financial efficiency, shared infrastructure, peer review, mentoring, leave arrangements and data collection. Multidisciplinary practice may further support integrated care and centres of excellence, provided the legal, billing and governance structures are properly established.*

### Q What regulatory framework currently allows multidisciplinary practice?

*Dr Rajesh Patel stated that the relevant framework includes the HPCSA ethical rule for multidisciplinary practice, while also noting that it applies to all professions regulated by the HPCSA. He also highlighted Regulation 5 of the Medical Schemes Act as important for billing structures in group and multidisciplinary practice. He indicated that the regulatory framework makes provision for multidisciplinary practices to be identified and to invoice funders, but that funders still need to adjust as implementation evolves.*

### Q How can a multidisciplinary mental healthcare model work in practice?

*Dr Eugene Allers described a contracted multi-professional team including psychiatrists, psychologists, occupational therapists and an anaesthetist, connected through an electronic health record and governed through contractual arrangements. The model includes SLAs with the hospital, discipline representation on a board, regular risk management meetings, quality data reporting and hybrid billing arrangements.*

**Q What is the most sustainable financial model for private practice?**

*Dr Evangelo Apostoleris responded that “it depends” on the community served, the practitioner’s stage of career and the practice environment. He emphasised physician leadership, understanding practice data, proper legal and accounting advice, use of an incorporated structure where appropriate, monthly business metrics, and movement towards value-based care once sufficient data is available.*

**Q How does a multidisciplinary oncology team operate, and should participation be remunerated?**

*Prof Chris Joseph described an oncology MDT that began in 2009 with a small group and grew to more than 30 specialists and allied professionals. It meets weekly and discusses around 200 cases per year, with the purpose of streamlining care, ensuring appropriate investigations and avoiding unnecessary interventions. The broader discussion supported the principle that MDT participation is time-based work and may require specific funding rather than being treated as an unpaid extension of normal clinical service.*

**Q Is direct doctor employment likely to increase?**

*Dr Karisha Quarrie described doctor employment or contracting as likely to become more prominent as healthcare delivery models change. She noted possible advantages such as reduced individual administrative burden, leave arrangements and limited vicarious liability, but also disadvantages such as performance management and loss of independence. She emphasised that any model would require co-creation, fairness, ethics and clarity on funding.*

**Q Can the private sector help train specialists and subspecialists?**

*Prof Ashraf Coovadia and Dr Sue Tager both indicated that private-sector involvement is already happening and is increasingly necessary. Prof Coovadia noted that training can no longer be limited to the public sector, while Dr Tager explained the Wits Donald Gordon Medical Centre model, where hospital profits support training posts, academic governance structures and a public-private liver transplant partnership.*

**Q Can private practices sponsor registrar training posts?**

*The answer was presented as possible, depending on the university and department. Dr Sue Tager discussed the concept of “local supernumerary” posts, where a registrar has a sponsor but obtains a training number without state funding. She cautioned that this raises concerns about equity and requires further discussion.*

## PRACTICAL TAKEAWAYS

### 01

#### For Private Practitioners & SAPPF Members

The session underscored the importance of taking practice structure seriously. Practitioners considering group practice should obtain proper legal and accounting advice, review financial statements and legal agreements, define income and cost-sharing arrangements, and establish dispute-resolution protocols before committing.

### 02

#### For Established Practices

The discussion highlighted the need to invest in outcomes measurement, electronic health records, clinical audit and business metrics. Practices that can demonstrate quality, efficiency and outcomes will be better placed to negotiate with funders and participate in value-based care.

### 03

#### For Healthcare Stakeholders

The session pointed to the need for clearer reimbursement models for multidisciplinary work, especially MDT participation. Where clinicians invest time in governance, case review, care coordination, clinical risk management or academic work, payment models should recognise that work appropriately and ethically.

### 04

#### For SAPPF Leadership

The session provides a strong basis for future workstreams on multidisciplinary practice models, doctor employment frameworks, funder engagement, private-sector training accreditation and business education for doctors. It also suggests that SAPPF can play a convening role between practitioners, hospital groups, funders, universities and regulatory bodies.

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

- Encourage SAPPF members to explore group practice and multidisciplinary practice models where clinically and financially appropriate.
- Develop practical guidance for practitioners on setting up group practices, including legal structure, income distribution, expense-sharing, leadership, leave, on-call arrangements, patient ownership and dispute resolution.
- Promote outcomes measurement and clinical audit as core components of sustainable private practice.
- Engage funders on mechanisms to recognise and remunerate multidisciplinary team participation.
- Clarify the practical implications of HPCSA ethical rules, PCNS coding and Regulation 5 of the Medical Schemes Act for multidisciplinary practices.
- Explore ethical and standardised models for doctor employment or contracting, including governance and non-clinical roles.
- Support business education for young doctors, registrars and specialists entering private practice.
- Work with universities, hospital groups and regulators to expand accredited private-sector training platforms.
- Ensure private-sector training models create additional training capacity rather than weakening the public-sector platform.
- Continue policy dialogue on local supernumerary posts, including equity concerns and funding responsibilities.
- Advocate for governance structures that allow private practices to become recognised academic training environments.

## QUOTATIONS

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*“It depends. It depends on the community that you service.”*

*“The patient’s central to what we do.”*

*“The secret is you have to have contractual arrangements.”*

*“Without well-trained doctors, we do not have a healthcare system.”*

*“It’s scalable. It has to be scalable. If it’s not, we’re in trouble.”*

## SESSION 3

# Data Driven Healthcare

**DATE:** 6 June 2026**MODERATOR:** Dr Simon Strachan**SPEAKERS:** Dr Chris G Mathew; Dr Conrad Mashiloane; Luis da Silva; Thoneshan Naidoo; Matt Zylstra

## EXECUTIVE SUMMARY

The session examined the role of data in enabling higher-quality, more efficient and more accountable healthcare in the South African private healthcare environment. Dr Simon Strachan opened the discussion by linking data-driven healthcare to wider conference themes, including value-based care, outcomes measurement, coding reform, innovation and the need for healthcare providers to take a more active role in shaping future models of care.

A central focus of the discussion was that data quality begins at the point of care. Speakers emphasised that accurate clinical records, ethical and comprehensive coding, interoperable electronic health records, and appropriate consent and governance frameworks are essential if healthcare data is to support meaningful outcomes measurement, reimbursement reform and patient-centred care. The session also highlighted that claims and billing data alone provide an incomplete view of clinical reality.

Panellists recognised the potential of electronic health records, health information exchanges, structured data, AI and analytics, but repeatedly cautioned that poor-quality data, fragmented systems, unclear ownership concepts, weak interoperability and low trust between stakeholders could undermine these opportunities.

The most important conclusion was that data-driven healthcare cannot be reduced to technology alone. It requires common standards, accurate coding, transparent governance, patient consent, practitioner participation, collaboration between funders and providers, and a shared commitment to using data to improve outcomes rather than merely control cost.



## KEY THEMES & INSIGHTS

### Data as the foundation of value-based healthcare

The session repeatedly linked data to value-based care. Speakers noted that outcomes, quality, efficiency and alternative reimbursement models cannot be meaningfully developed without accurate, standardised and clinically relevant data.

### Coding reform and the limits of current systems

Dr Strachan outlined significant challenges in South Africa's coding environment, including outdated reference structures, multiple coding systems, non-remunerated published codes, CPT licensing issues, funder-specific processes and the absence of effective mechanisms for collective engagement. The proposed South African Classification of Healthcare Interventions was presented as a possible multi-stakeholder governance mechanism.

### Record keeping and clinical documentation

Conrad Mashiloane emphasised that data starts with proper records and good record keeping. He linked clinical documentation directly to ethical coding and the need for a common coding platform.

### Electronic health records and interoperability

The panel identified electronic records as essential but insufficient on their own. Portability, open standards and interoperability were described as major practical challenges. Chris Mathew highlighted the importance of human-centred design, culture change and structured data.

### Data ownership, custodianship and consent

Luis da Silva and Matt Zylstra discussed POPIA-related concepts, distinguishing between rights in personal information, custodianship, processing obligations and consent. The discussion moved away from a narrow ownership debate toward responsible, governed use of data.

### Trust and governance

Thoneshan Naidoo stressed that healthcare runs on trust as well as data. Speakers agreed that data sharing depends on secure governance, transparency and a clear patient benefit.

### AI as dependent on data quality

AI was framed as promising but dependent on the quality and structure of underlying data. The session cautioned that poor data would lead to poor automated decisions.

### Additional insights raised during the discussion

|                                                                                                                                                             |                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| ◆ <i>Accurate data is foundational to value-based care, outcomes measurement and sustainable healthcare reform.</i>                                         | ◆ <i>Coding is not only an administrative function; it is the language through which clinical work is represented to funders and the broader system.</i> |
| ◆ <i>Outdated or incomplete coding systems may lead practitioners to code expediently, which can distort how their practices are understood by funders.</i> | ◆ <i>Data sharing must be governed, secure and patient-centred.</i>                                                                                      |
| ◆ <i>The industry challenge is not only technical; it is also strategic, commercial and trust-based.</i>                                                    | ◆ <i>Healthcare providers need to participate actively in deciding what data is collected, how it is interpreted, and how it is used.</i>                |

## KEY QUESTIONS & RESPONSES

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**Q What are the main sources of healthcare data, and how can healthcare professionals improve data quality?**

*The discussion identified clinical records, electronic health records, procedural codes, ICD diagnostic codes, claims data, laboratory data, pharmacy data, imaging data, wearable devices and patient-generated data as sources of healthcare data. The response emphasised that quality begins with proper record keeping, accurate clinical documentation, ethical coding and the use of interoperable systems.*

**Q Who owns healthcare data?**

*The answer was not framed as simple ownership. The discussion distinguished between the patient as the data subject, healthcare providers and schemes as custodians or processors, and the need for consent and responsible processing under POPIA. One view expressed was that the more important question is how data is used to improve patient outcomes while protecting privacy and maintaining trust.*

**Q Is billing data sufficient for data-driven healthcare?**

*No. Billing data was described as limited because it reflects what was billed, but not necessarily the full clinical condition, patient journey or outcome. Speakers supported the need for richer clinical datasets, structured data and appropriate clinical context.*

**Q What role should electronic health records play?**

*Electronic health records were presented as important infrastructure for better documentation, data collection, efficiency and future use of analytics and AI. However, concerns were raised about portability, interoperability and the need for systems that communicate with each other rather than locking practitioners into isolated platforms.*

**Q What does interoperability mean in practical terms?**

*Interoperability was discussed at several levels: technical connectivity, syntactic compatibility and semantic interoperability. The key point was that systems must be able to exchange information in a standardised way, using common structures and code sets, so that data can be understood across different platforms.*

**Q What is needed before AI can be useful in healthcare?**

*The session emphasised that AI depends on quality data. Without accurate, structured and clinically meaningful data, AI risks automating poor or inaccurate decisions. AI was described as part of a broader transformation journey involving data, electronic health records and analytics.*

## PRACTICAL TAKEAWAYS

|                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>01</b><br><b>Documentation &amp; Coding Discipline</b><br>Private practitioners should prioritise accurate clinical documentation, appropriate consent processes and ethical coding in daily practice.            | <b>02</b><br><b>Interoperable Records</b><br>Practices using electronic health records should consider whether their systems support portability, interoperability and structured data capture.                                                  |
| <b>03</b><br><b>Collective Coding Reform</b><br>Practitioner groups should engage collectively on coding reform and should not rely solely on funder-held data to define clinical value or practice patterns.        | <b>04</b><br><b>Data Quality &amp; Reimbursement</b><br>SAPPF members should recognise that data quality affects reimbursement, managed care, fraud/waste/abuse assessments, outcomes measurement and value-based contracting.                   |
| <b>05</b><br><b>Shared Data Standards</b><br>Healthcare stakeholders should focus on shared standards, transparent governance and patient benefit when designing data-sharing or health information exchange models. | <b>06</b><br><b>Proposed Follow-Up Topics</b><br>It was proposed that follow-up sessions on POPIA-compliant consent, practical electronic health record adoption, coding education, and the development of discipline-specific outcome datasets. |

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

- Advance the proposed South African Classification of Healthcare Interventions as an independent, multi-stakeholder coding governance platform.
- Improve coding education across healthcare professional groups, with emphasis on ethical, accurate and clinically meaningful coding.
- Promote electronic health record adoption while ensuring portability, interoperability and common standards.
- Develop clear practice-level POPIA consent processes that explain what data is collected and how it may be used or shared.
- Encourage practitioner involvement in defining datasets for outcomes monitoring and value-based care.
- Support national or industry-level standards for interoperability, including common messaging and coding frameworks.
- Ensure AI implementation is preceded by improvements in data quality, data governance and clinical oversight.

- Explore mechanisms for secure, governed and clinically meaningful data sharing between practitioners, funders, hospitals and other stakeholders.
- Avoid using claims data alone as a proxy for clinical quality, complexity or outcomes.
- Consider regulatory or industry-level solutions where commercial interests prevent effective interoperability or data sharing.

## QUOTATIONS

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*“Data starts with proper records, good record keeping.”*

*“If the data is wrong, the decisions will be wrong.”*

*“Rubbish in, rubbish out.”*

*“You cannot manage what you don’t measure.”*

*“Healthcare data is no longer just created in hospitals and consulting rooms.”*

## SESSION 4

# Social Media Medicolegal Implications for Health Care Providers

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**DATE:** 6 June 2026

**SPEAKERS:** Dr Blesset Nkambule

## EXECUTIVE SUMMARY

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This session examined the opportunities and risks associated with healthcare professionals' use of social media, with a particular focus on medicolegal exposure, professional reputation, patient confidentiality, advertising standards, professional boundaries, and regulatory scrutiny. Dr Blesset Nkambule approached the subject from a medical indemnity and medicolegal perspective, drawing on practical examples and case-based scenarios encountered by healthcare professionals.

The central message was that social media is a powerful professional tool, but one that must be used with vigilance and discipline. The speaker acknowledged that social media could support patient education, professional visibility, networking, public health advocacy and practice growth. At the same time, she emphasised that a single post, image, endorsement, comment, tag or review may attract complaints, reputational harm, or regulatory investigation.

The overall tone of the session was practical, cautionary and constructive. Rather than discouraging healthcare professionals from using social media altogether, the speaker encouraged responsible engagement. She highlighted the importance of separating personal and professional profiles, protecting patient information, ensuring consent, avoiding misleading advertising, managing online reviews carefully, and maintaining professional boundaries.

A key conclusion was that healthcare professionals cannot treat social media as an informal or risk-free environment. Patients, colleagues, competitors, regulators, and the wider public may all view and interpret online content. Practitioners should therefore apply the same standards of professionalism, confidentiality, evidence-based communication and ethical judgment online as they would in clinical practice.

## KEY THEMES & INSIGHTS

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### **Social media as both opportunity and risk**

The speaker described social media as a powerful tool for professional visibility, patient education, networking, advocacy and practice development. However, she emphasised that its speed and reach also increase the risk of reputational damage, regulatory complaints and medicolegal exposure.

### Professional visibility must remain ethical

The session distinguished between responsible professional visibility and inappropriate advertising. Practitioners were cautioned against misleading claims, misrepresentation of credentials, canvassing, exaggerated claims, and association with products or campaigns that are not evidence-based.

### Patient confidentiality and consent are central

A recurring theme was the importance of protecting patient information. Even where names are removed, patients may still be identifiable through images, tattoos, clinical details, context or other markers. Consent must be specific and appropriate before patient-related content is posted.

### Online conduct can affect professional boundaries

The speaker warned that social media interactions with patients can create boundary problems. Liking, commenting on, or engaging with a patient's personal content may be misinterpreted and may affect the doctor-patient relationship, especially in smaller communities.

### The internet creates a lasting professional footprint

The speaker noted that online activity may remain discoverable and that patients and colleagues may search for information about practitioners. Practitioners were encouraged to understand and manage their digital footprint.

### Complaints and reviews require careful handling

Negative reviews or online criticism may not always amount to defamation, particularly where the statement is true. The speaker advised against overreacting publicly, warning that legal escalation can sometimes amplify attention and create further reputational harm.

### Healthcare professionals have a role in countering misinformation

The discussion acknowledged that non-regulated wellness voices and influencers may occupy online health spaces. Several contributions emphasised that credible healthcare professionals can help provide evidence-based information and balance misleading narratives.

### Additional insights raised during the discussion

|                                                                                                                                                 |                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| ◆ <i>Healthcare professionals should recognise that social media can be both beneficial and risky.</i>                                          | ◆ <i>Patients, competitors and regulators may all be present on the same platforms used by practitioners.</i>                       |
| ◆ <i>Professional visibility can be achieved cheaply and quickly online, but reputational harm can occur just as quickly.</i>                   | ◆ <i>Social media is not a safe space for venting workplace frustrations or internal grievances.</i>                                |
| ◆ <i>Healthcare professionals should not assume that consent, anonymisation or good intentions remove all risk from online posts.</i>           | ◆ <i>Practitioners should be careful about online friendships with patients and should maintain appropriate boundaries.</i>         |
| ◆ <i>Negative online reviews should be managed carefully, with a focus on proportionate and practical resolution.</i>                           | ◆ <i>Ethical practitioners and credible healthcare voices should consider occupying the online space to counter misinformation.</i> |
| ◆ <i>Advertising agencies, influencers and marketing partners must understand the regulatory limits applicable to healthcare professionals.</i> |                                                                                                                                     |

## KEY QUESTIONS & RESPONSES

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**Q Are doctors allowed to prevent patients from recording consultations, including audio or video recordings?**

*The answer given was that, under the relevant communications law as described by the speaker, a party involved in a conversation may record that conversation without the consent of the other party. Doctors may still manage the environment by displaying signs requesting that patients do not record without consent. The speaker advised practitioners not to respond aggressively if they discover that a patient is recording. Instead, they should try to understand the reason. In some cases, a patient may record because they are worried they will forget the advice or want a spouse or caregiver to hear the explanation. This can create an opportunity to simplify the information or involve the appropriate support person in the patient's care.*

**Q What are the risks of using influencers to market a medical practice or allowing brands to use healthcare professionals for endorsements?**

*The speaker stated that the starting point is that the HPCSA does not allow canvassing or claims that place a practitioner inappropriately above others. Influencer content can be risky because influencers may exaggerate claims or present the practitioner in a way that could jeopardise the practitioner's position before the regulator. If an advertising company or influencer is used, their content must align with the ethical and regulatory obligations of healthcare professionals. On product endorsements, the speaker advised that doctors must do their homework and ensure that any product is credible and evidence based. She also noted that transparency is important when someone has received payment or free treatment, because the public must be able to understand the possibility of bias.*

**Q Why should doctors use social media at all, beyond marketing their practices?**

*The concern was raised that social media exposes doctors to unnecessary criticism and risk, and that the platform belongs to the public rather than to the medical profession. The response was that some practitioners have the appetite and capacity to use social media constructively, including through podcasts and educational campaigns. The speaker argued that doctors can help set a more accurate public narrative because patients are already encountering misinformation online. If doctors do not participate, they may still have to correct misinformation during consultations after patients have been influenced by unreliable online sources.*

**Q Can social media be useful for patient communication and practice visibility?**

*A practical example was shared of a practice that opened a dedicated WhatsApp line during COVID-19, with dual authentication, and continued using it for patient communication. The same practice also developed a podcast for parents, which reportedly generated substantial awareness for the practice. The example illustrated that digital platforms may support communication, education and visibility when used intentionally and responsibly.*

## PRACTICAL TAKEAWAYS

### 01

#### For Private Healthcare Practitioners

For private healthcare practitioners, the main takeaway is that social media should be approached as a professional environment, not merely a casual communication platform. Practitioners should consider what a patient, regulator, colleague or competitor may infer from a post before publishing it.

### 02

#### For SAPPF Members

SAPPF members should maintain clear separation between personal and professional accounts, ensure patient data is properly anonymised, obtain appropriate consent, avoid emotional or impulsive posts, and ensure that content remains factual, professional and evidence based.

### 03

#### For Healthcare Stakeholders

Healthcare stakeholders should recognise that credible health communication online is increasingly important. Where healthcare professionals choose not to participate, less credible voices may shape patient expectations and public understanding.

### 04

#### For Professional Bodies

Professional bodies may wish to provide further guidance, templates or practical tools to help practitioners navigate social media, advertising rules, influencer relationships, patient reviews, WhatsApp communication, and digital professionalism.

### 05

#### The SAFE POST Framework

The speaker's "SAFE POST" framework offered a practical checklist: separate accounts, anonymise patient data, stick to facts rather than feelings, ensure consent, remain professional, be objective and evidence-based, post safely, and take time to review before posting.

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

- Healthcare professionals should review their current social media profiles and online footprint to assess whether publicly available information reflects their professional identity accurately.
- Practices should consider developing internal social media policies covering patient images, consent, reviews, advertising, influencer arrangements, staff posts, professional boundaries and patient communication platforms.
- Practitioners should avoid posting patient-related content unless consent, anonymisation and professional purpose are all clearly established.
- Private practices using marketing agencies or influencers should ensure that all parties understand HPCSA-related ethical limits, including risks around canvassing, exaggeration, inducement and misleading claims.
- Healthcare professionals should avoid endorsing products or brands unless the content is evidence-based, transparent, ethical and consistent with professional obligations.
- Practices should develop a clear approach to managing negative reviews, including when to engage privately, when to request removal, when to seek advice, and when legal escalation may create more harm than benefit.
- Professional bodies may consider further education for members on digital professionalism, social media advertising, patient confidentiality, and the medicolegal implications of online communication.

## QUOTATIONS

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*“One selfie, one caption, and one career on the line.”*

*“Social media is a world of opportunity.”*

*“The internet doesn’t forget.”*

*“Oversharing is not caring.”*

*“Social media is not a safe space for you to vent your frustrations.”*

## SESSION 5

# Financing Healthcare

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**DATE:** 7 June 2026

**MODERATOR:** Dr Richard Tuft

**SPEAKERS:** Mark Hyman; Prof Roseanne Harris; Christoff Raath; Charlton Murove; Dr Vuyo Gqola; Dr Mark Phipson

## EXECUTIVE SUMMARY

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The session addressed healthcare financing in South Africa's private healthcare environment, with a particular focus on the tension between affordability, access, medical scheme sustainability, member protection, medical inflation, gap cover and the evolving regulatory environment. Dr Richard Tuft framed the discussion as a relatively open and conversational panel, beginning with an example from radiology to illustrate how well-intentioned value-based or appropriateness initiatives can fail when evidence, technology, clinician behaviour and implementation conditions do not align.

Mark Hyman approached healthcare financing from the perspective of medical scheme members. He argued that financing failures are experienced by members not as abstract actuarial or policy matters, but as declined authorisations, unexpected co-payments, benefit routing errors, exhausted benefits, PMB disputes and out-of-pocket costs. His main concern was that schemes must not shift costs onto members through opaque processes, outdated PMB interpretations, rigid algorithms or benefit silos that fail to reflect the patient's real clinical pathway.

Roseanne Harris focused on medical inflation and explained why contribution increases can exceed tariff increases. She emphasised that medical scheme costs are driven not only by tariff adjustments, but also by changing intensity of care, more events per patient, ageing and deteriorating risk pools, technology and regulatory constraints. Her contribution presented sustainability as a shared challenge, proposing that the sector should seek a "win-win-win" model: improved affordability and access for members, a more robust risk pool for schemes, and remuneration models that allow practitioners to work at the top of their expertise without compromising overall remuneration.

Christoff Raath offered a pragmatic view of where the system may be heading. While broadly agreeing with concerns about member experience and inefficiencies, he challenged the assumption that members truly understand the cost of healthcare or can afford the kind of comprehensive cover being discussed. He argued that rationing is unavoidable because resources are finite and demand is potentially unlimited. His central warning was that, unless regulation is fixed, the system may continue shifting from community rating towards de facto risk rating through a combination of medical scheme products, gap cover and primary healthcare insurance products. Charlton Murove's opening remarks supported the need to diagnose the reasons for gap cover and related insurance products entering the market, rather than treating them only as regulatory anomalies.

## KEY THEMES & INSIGHTS

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### **Member experience and financial harm**

Mark Hyman emphasised that members experience healthcare financing through practical barriers: declined authorisations, unexpected co-payments, benefits paid from the wrong basket, oncology benefits running out, and PMB disputes. He argued that avoidable out-of-pocket exposure should be treated as a formal performance metric because administrative failures can translate directly into member harm.

### **PMBs, clinical evolution and outdated funding logic**

A major theme was the mismatch between older PMB frameworks and modern clinical practice. Mark Hyman argued that 2003-era definitions and algorithms should not become 2026 funding ceilings, especially where medicine, oncology, biologics, precision medicine, rehabilitation, assistive technology and palliative care have advanced.

### **Whole-pathway costing rather than line-item costing**

The session challenged narrow cost assessments. Mark Hyman argued that the cheapest item is not always the lowest-cost pathway if a more appropriate intervention prevents hospitalisation, injury, deterioration, caregiver burden or avoidable complaints.

### **Medical inflation beyond tariff increases**

Roseanne Harris explained that contribution increases differ from tariff increases because the “basket” of healthcare services changes over time. More intensive care, more events per patient, technology, ageing and deteriorating risk profiles all contribute to cost escalation.

### **Risk-pool deterioration and affordability**

Roseanne Harris and Christoff Raath both highlighted the challenge of a stagnant or deteriorating medical scheme risk pool. It was noted that the medical scheme population has remained around nine million people and has become older and sicker. This increases claims pressure and undermines cross-subsidisation.

### **Rationing and sustainability**

Christoff Raath emphasised that healthcare systems must make rationing decisions because resources are scarce and demand is potentially unlimited. He argued that the affordability limit is ultimately set by household budgets.

### **Shift towards insurance-based supplementation**

Christoff Raath warned that the market may be moving towards a more complex mix of medical scheme cover, gap cover and primary healthcare insurance products. He described this as a probable future rather than necessarily a desirable one and linked it to regulatory gaps such as community rating and open enrolment without mandatory cover or risk equalisation.

### **Need for regulatory reform**

A consistent underlying theme was that many of the system’s problems cannot be solved only through scheme-level or provider-level action. Christoff Raath noted that meaningful solutions may require legislative reform but also observed that fixing medical schemes may not be politically popular.

## The Future of Healthcare Financing

Charlton Murove discussed the future of healthcare financing in South Africa, emphasising that the various legal challenges to the National Health Insurance (NHI) should be viewed as complementary efforts that will collectively shape the future of healthcare policy. He highlighted the growing use of gap cover and medical insurance as evidence of weaknesses within the current medical scheme system. Murove concluded that sustainable healthcare reform requires better alignment of incentives so that funding models reward quality care and improved patient outcomes rather than healthcare utilisation.

## Value-Based Healthcare at GEMS

Dr Vuyo Gqola, Chief Operating Officer of GEMS, outlined the scheme's transition towards value-based healthcare, arguing that reimbursement should increasingly reward quality, patient outcomes, and care coordination rather than service volume. She highlighted successful multidisciplinary programmes for chronic disease, rehabilitation, obesity management, and palliative care, demonstrating improved clinical outcomes and reduced healthcare costs. Although value-based contracting requires significant investment and robust outcome measurement, she described it as essential for delivering sustainable, patient-centred healthcare in South Africa.

## Restoring the Doctor-Patient Relationship

Dr Mark Phipson emphasised that healthcare should remain centred on the doctor-patient relationship, with medical schemes supporting rather than directing clinical decision-making. He highlighted the growing administrative burden placed on practitioners by funders and argued that patients should take greater responsibility for engaging with their medical schemes. While acknowledging concerns about fraud and inappropriate billing within the profession, he also cautioned that Designated Service Provider (DSP) arrangements must be transparent, flexible, and preserve patient choice and trust.

## Improving Funding Motivations

Mark Hyman from Medichcek emphasised that funding motivations should be comprehensive clinical documents rather than simple administrative requests. He recommended including accurate diagnoses, ICD-10 codes, clinical findings, treatment history, PMB requirements, evidence-based medicine, and patient-specific clinical circumstances to clearly demonstrate medical necessity. Well-prepared motivations improve communication between healthcare providers and medical schemes, facilitate informed funding decisions, reduce unnecessary disputes and delays, and contribute to a more transparent, efficient, and patient-centred funding process.

## Additional insights raised during the discussion

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ◆ <i>The moderator noted that radiology has experienced a significant increase in utilisation, driven by multiple factors including changing disease profiles, ageing demographics, technological advances and more defensive medicine.</i> | ◆ <i>Clinical decision support in radiology was presented as a well-intentioned initiative aimed at improving appropriateness, but implementation was limited by the need for electronic requests, clinician behaviour, evidence from international studies and the limitations of a clunky legacy system.</i> |
| ◆ <i>A recurring concern was that healthcare financing debates often become technical, while patients experience the consequences in practical and financial terms.</i>                                                                     | ◆ <i>Several contributions pointed to the need for better alignment between clinical pathways, funding pathways and benefit design.</i>                                                                                                                                                                        |

◆ The sustainability of medical schemes was repeatedly linked to the size and composition of the risk pool.

◆ Gap cover and supplementary insurance were discussed as symptoms of broader structural issues in the medical scheme environment, rather than isolated products.

## KEY QUESTIONS & RESPONSES

### **Q What are the main drivers of escalating healthcare costs, and is the current funding model sustainable?**

A delegate noted that healthcare costs are rising because of multiple factors, including inflation, exchange rate fluctuations, an ageing population, increasing chronic disease, and advances in medical technology. Given South Africa's slow economic growth and limited fiscal capacity, simply making incremental changes to the current system is unlikely to solve the affordability crisis. The panel agreed that the current funding model is under considerable pressure. There was discussion about whether Prescribed Minimum Benefits (PMBs) remain fit for purpose, with some panellists suggesting that continually expanding PMBs to include increasingly expensive therapies risks making healthcare unaffordable. More affordable benefit options that allow members to make informed choices about their level of cover were proposed as a potential solution.

### **Q Should Low-Cost Benefit Options (LCBOs) be introduced?**

Panel members explained that proposals for Low-Cost Benefit Options had previously been developed but were never implemented. They argued that these products could provide affordable healthcare cover for millions of South Africans who earn too much to qualify for public healthcare but cannot afford traditional medical scheme membership. The panel expressed concern that, in the absence of LCBOs, many consumers have turned to health insurance products that often provide limited protection during serious illness or hospitalisation. Properly regulated LCBOs were viewed as an opportunity to expand access to affordable private healthcare while providing greater consumer protection.

### **Q Should South Africa continue to view public and private healthcare as separate systems?**

Delegates argued that South Africa effectively has one healthcare system serving the entire population and that future reforms should reflect this reality. The panel agreed that healthcare providers, funders, regulators and government must work collaboratively rather than as separate sectors. Given the country's significant social and economic inequalities, private healthcare cannot function independently of the broader health system. Sustainable reform will require shared responsibility and collective problem-solving.

### **Q How should healthcare professionals prepare for future multilateral negotiations with funders?**

A delegate raised concerns that healthcare professionals may not be adequately prepared for anticipated multilateral negotiations, particularly because many specialist groups lack reliable data on practice costs, utilisation and outcomes. The panel encouraged professional societies to begin collecting robust economic and clinical data to support future negotiations. They also challenged healthcare professionals to broaden their focus beyond clinical practice and become more actively involved in healthcare policy and system reform.

**Q What role should professional organisations play in healthcare reform?**

*Panel members emphasised that professional organisations are uniquely positioned to influence healthcare reform because their members work across the public and private sectors, academia, government and healthcare administration. They encouraged professional societies to facilitate discussions on broader healthcare system issues, advocate for evidence-based reform, and bring together stakeholders from across the healthcare sector to develop practical solutions.*

**Q Why do so many patients misunderstand their medical scheme benefits?**

*Delegates observed that many patients purchase healthcare cover without fully understanding what their benefits include. Problems frequently arise when patients assume that an authorisation guarantees payment or are unaware of referral requirements and Designated Service Provider (DSP) rules. The panel acknowledged that communication remains a significant challenge. Medical schemes, brokers and healthcare providers all have a responsibility to ensure that patients understand their benefits before treatment so that unexpected financial liabilities can be avoided.*

**Q What role do brokers play in patient understanding of healthcare cover?**

*Some delegates questioned whether brokers adequately explain healthcare products to consumers. The discussion highlighted concerns that purchasing decisions are often driven by price rather than an understanding of the benefits and limitations of different products. The panel suggested that improved consumer education and greater accountability would help patients make more informed choices regarding healthcare cover.*

**Q How should fraud, waste and abuse be managed without compromising patient care?**

*Delegates questioned the balance between protecting medical scheme funds and ensuring that patients receive timely access to appropriate care. The panel explained that administrators have a responsibility to safeguard members' funds by identifying fraud, waste and inappropriate utilisation. However, they agreed that administrative controls should not become barriers to clinically appropriate care. Greater collaboration between healthcare professionals and funders was viewed as the best way to improve efficiency while maintaining quality.*

**Q How can value-based care be applied to mental health services?**

*A psychiatrist highlighted that mental healthcare often requires multidisciplinary, community-based management that extends beyond conventional consultation models. The panel agreed that value-based mental healthcare programmes should be co-designed by clinicians and funders. Such programmes should reward long-term patient outcomes, relapse prevention and coordinated multidisciplinary care rather than focusing solely on short-term cost containment.*

**Q Is strengthening primary care the solution to improving healthcare sustainability?**

*A primary care specialist argued that many of South Africa's healthcare challenges stem from inadequate investment in community-based primary care. Chronic disease, lifestyle medicine, behavioural change and geriatric care should be managed primarily in the community rather than by hospital specialists. The panel broadly agreed that strengthening primary care would improve patient outcomes, reduce unnecessary hospital referrals, lower healthcare costs and alleviate clinician burnout. Greater investment in multidisciplinary primary care teams was identified as an important strategy for improving the efficiency and sustainability of the healthcare system.*

## PRACTICAL TAKEAWAYS

### 01

#### For Private Healthcare Practitioners

For private healthcare practitioners, the session highlights the importance of understanding how funding decisions, benefit routing, authorisation delays, gap cover and PMB interpretations affect patients' ability to access care and settle accounts.

### 02

#### For SAPPF Members

For SAPPF members, the discussion reinforces the value of documenting examples where managed-care rules, benefit silos or outdated funding interpretations compromise clinically appropriate care.

### 03

#### For Healthcare Stakeholders

For healthcare stakeholders, the session underscores the need to evaluate healthcare costs at pathway level rather than only at line-item level, particularly where a higher upfront cost may prevent downstream harm or expenditure.

### 04

#### Bringing Stakeholders Together

The session demonstrates the value of bringing patient advocates, scheme representatives, actuaries and practitioner representatives into the same conversation, because each sees a different part of the financing problem.

### 05

#### For Policy & Regulatory Engagement

For policy and regulatory engagement, the session points to the need for updated PMB frameworks, clearer funding rules, improved transparency, and policy mechanisms that support a healthier risk pool.

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

- Out-of-pocket exposure should be considered as a measurable indicator of system performance, particularly where payment arises from benefit-routing failures, appeal delays or unclear scheme communication.
- Medical schemes should be expected to apply protocols, formularies, DSPs, managed-care rules, PMB algorithms and option limits transparently, lawfully, rationally and with meaningful exception processes.
- PMB definitions and algorithms require review to ensure that they remain clinically appropriate in light of current medicine, technology and patient needs.
- Funding decisions should consider the full care pathway, not only the immediate cost of an item, intervention or device.
- Medical scheme sustainability requires attention to the risk pool, including the challenge of older and sicker members remaining in the system while younger and healthier lives do not join or leave.
- The sector should explore remuneration models that allow practitioners to work at the top of their expertise while improving affordability and system capacity.

- Policy reform may be required to address structural weaknesses created by community rating and open enrolment without sufficient balancing mechanisms such as mandatory cover or risk equalisation.
- The growth of gap cover and primary healthcare insurance products should be treated as a signal of structural pressure in the medical scheme environment.
- Strengthen understanding of medical scheme funding rules, PMBs, and DSP requirements.
- Submit comprehensive, evidence-based funding motivations with appropriate clinical justification.
- Discuss treatment costs, co-payments, and funding limitations with patients before treatment.
- Encourage patients to understand their medical scheme benefits and responsibilities.
- Participate in multidisciplinary models of care.
- Collect and use patient-reported outcome and experience measures to assess quality.

### Recommendations for Medical Schemes

- Expand value-based contracting that rewards quality and patient outcomes.
- Support multidisciplinary care through reimbursement models.

### Improve transparency around

- Benefit structures
- Funding protocols
- DSP requirements
- Appeals processes
- Patient co-payments
- Simplify administrative processes and reduce unnecessary bureaucracy.
- Invest in systems to measure clinical outcomes.
- Introduce greater flexibility and clear exception processes for DSP arrangements.

### Recommendations for Professional Organisations

- Continue engaging with policymakers and funders on healthcare financing reform.
- Educate practitioners on funding motivations and evolving reimbursement models.
- Advocate for funding models that reward quality, multidisciplinary care, and patient outcomes.
- Promote collaboration between healthcare providers and funders.

### Policy Considerations

- Investigate the factors driving increased use of medical insurance products and gap cover.
- Align financial incentives across the healthcare system to reward health outcomes rather than service volume.
- Continue transitioning from fee-for-service to value-based healthcare models.
- Recognise and reimburse multidisciplinary care for chronic disease, rehabilitation, obesity, prevention, and palliative care.
- Improve transparency of medical scheme benefits, funding protocols, and patient financial responsibilities.
- Reduce unnecessary administrative burdens while maintaining safeguards against fraud.

### Base funding decisions on

- Clinical necessity
- Evidence-based medicine
- Individual patient circumstances
- PMB requirements

- Preserve the doctor-patient relationship by ensuring funding mechanisms support clinical decision-making.

### **Key Strategic Priorities**

- Accelerate the transition to value-based healthcare.
- Align incentives across funders, providers, brokers, and patients.
- Improve transparency in healthcare funding and benefit design.
- Strengthen multidisciplinary models of care.
- Reduce administrative complexity.
- Maintain patient-centred care while improving quality, affordability, and access.

## **QUOTATIONS**

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*“The promise sold to a member must match the benefit delivered to the member.”*

*“Otherwise, balancing cost and access becomes something entirely different. It becomes cost-shifting.”*

*“Out-of-pocket expenses are a warning light for members of medical schemes.”*

*“The cheapest item is not always the lowest cost pathway.”*

*“A 2003 algorithm should not become a 2026 funding ceiling.”*

## SESSION 6

# Legal Angle: Don't Be Complacent – This Is Real

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**DATE:** 7 June 2026

**MODERATOR:** Dr Karlheinz Jehle

**SPEAKERS:** JP Ellis; Jaco van der Sandt; Dr Portia Nethononda; Arlene Steyl; Dr Simon Strachan; Mr Thoneshan Naidoo

## EXECUTIVE SUMMARY

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The session, titled “The Legal Angle”, examined the expanding legal, regulatory and operational pressures facing private healthcare practitioners in South Africa. The moderator opened by reflecting on how the medico-legal environment has changed over the past two to three decades, noting that clinical care is now only one part of a wider risk landscape that includes documentation, communication, systemic failures, digital evidence, professional autonomy, patient awareness, funding structures and regulatory strain.

A central part of the discussion was built around a clinical case involving a urology patient who suffered a recognised but serious complication following stone surgery. The case was used to explore what a practitioner should do in the first 24 hours after an adverse event. Panellists repeatedly emphasised that the first responsibility is patient care, clinical escalation and stabilisation. Legal defensiveness should not displace the immediate clinical duty to the patient.

The discussion then moved into communication with the patient and family, documentation, retrospective clinical notes, complaints processes, patient confidentiality and the role of indemnifiers. Panellists agreed that open, timely, clinically grounded communication can reduce mistrust and escalation, but they also recognised the practical reality that clinicians may be in theatre, exhausted, unsupported or dependent on hospital staff to relay information.

A further major theme was the impact of medical scheme audits and Section 59 processes. The discussion acknowledged the legitimate need for schemes to investigate fraud, waste and abuse, while also raising concerns about procedural fairness, power imbalance, poor communication, opaque algorithms, clawbacks or “recoveries”, and the significant burden that audits place on sole practitioners. The overall tone was candid, practical and sometimes robust, but remained focused on improving systems, protecting patients, and supporting principled private practice.

## KEY THEMES & INSIGHTS

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### **Patient care comes before legal defensiveness**

The panellists were clear that after an adverse event, the practitioner's first duty is to stabilise the patient and provide appropriate care. Legal and indemnity considerations follow but should not delay clinical escalation.

**Communication is a risk-management tool**

The discussion repeatedly returned to the importance of communication. Families may escalate concerns when they feel excluded or when delays are not explained. A short, honest, clinically accurate update can reduce mistrust.

**Documentation protects both patient care and professional accountability**

Documentation was treated as central to clinical governance. The record should show the complication, the response, the reasoning, the communication and the sequence of events. Retrospective entries should be transparent.

**Complaints processes help direct concerns constructively**

A practice-level complaints process may not prevent all claims, but it can provide a first route for patients or families to raise concerns. The discussion framed complaints handling as part of practice management and patient engagement.

**Adverse events occur within wider system constraints**

The case highlighted the doctor's reliance on theatre schedules, ward staff, hospital systems, radiology access and ICU availability. The moderator raised concern that doctors may carry legal exposure for failures or limitations in systems they do not fully control.

**Section 59 audits create major professional and operational pressure**

The discussion recognised the need to address fraud, waste and abuse, but also highlighted the strain of audits, retrospective recovery claims, coding disputes and the perceived lack of procedural fairness.

**Professional autonomy and remuneration are linked**

The moderator argued that doctors are expected to perform more communication, administrative, funding-related and medico-legal work, but this additional work is not necessarily reflected in remuneration.

**Section 59 of the Medical Schemes Act: Balancing Accountability and Fairness**

The panel reviewed the purpose of Section 59 of the Medical Schemes Act, which regulates reimbursement of healthcare providers and permits medical schemes to recover payments made as a result of fraud, waste, or abuse. While acknowledging the necessity of these powers to protect scheme beneficiaries, the discussion highlighted concerns regarding the way investigations are conducted.

Although the independent Section 59 investigation found no evidence of racial profiling by medical schemes, it identified deficiencies in procedural fairness, transparency, communication, and governance. The panel emphasised that practitioners should be afforded meaningful opportunities to respond before substantial recovery demands are issued and that clinical expertise should play a greater role in investigations.

**Fraud, Waste and Abuse Investigations**

Participants recognised that fraud detection is an essential responsibility of medical schemes. Most investigations arise from complaints lodged by scheme members rather than from routine profiling or automated algorithms.

Importantly, the panel distinguished between intentional fraud and administrative or coding errors. While deliberate fraud represents a relatively small proportion of cases, coding errors and misunderstandings

can still have profound consequences for individual practitioners. For those subjected to investigations, the financial and emotional impact can be considerable, particularly when recovery demands extend over several years.

### **The Importance of Collaboration Between Funders and Healthcare Professionals**

A recurring theme was the need for improved collaboration between medical schemes, professional societies, and regulators. Representatives described recent initiatives that have introduced Clinical Review Committees, mediation processes, and codes of good practice intended to improve fairness and communication.

Professional organisations such as SAPPF were presented as essential intermediaries, advocating for practitioners and contributing to the development of more transparent processes. The session reinforced that constructive engagement between stakeholders is preferable to adversarial approaches.

### **Collective Professional Support**

The panel strongly advised practitioners not to respond independently to verification letters or fraud investigations. Early engagement with specialist societies and professional organisations allows access to legal expertise, collective representation, and established communication channels with medical schemes.

This collaborative approach was identified as one of the most effective methods of protecting practitioners' interests while ensuring appropriate resolution of disputes.

### **Artificial Intelligence in Clinical Documentation**

The increasing use of AI-powered medical scribes generated significant discussion. The panel agreed that AI offers substantial opportunities to improve efficiency and reduce documentation burden. However, AI was consistently described as a clinical tool rather than a substitute for professional judgement.

The responsibility for clinical records remains entirely with the treating practitioner. Every AI-generated note should be reviewed, corrected where necessary, and formally approved before becoming part of the medical record. Failure to verify AI-generated documentation could expose practitioners to significant medico-legal risk.

### **Informed Consent and Transparency**

The use of AI documentation introduces additional ethical and legal responsibilities. Patients should be informed when consultations are recorded for AI-assisted documentation, and practices should clearly explain how recordings are used, stored, or deleted.

The panel emphasised that transparency strengthens trust and may reduce future disputes regarding documentation practices.

### **Cybersecurity and Data Governance**

Digital healthcare increasingly depends on cloud-based software and international technology providers. Despite outsourcing technological services, practitioners remain legally responsible for protecting patient information.

The discussion highlighted the importance of understanding where patient data are stored, whether appropriate security measures such as encryption and two-factor authentication are in place, and whether software providers comply with applicable privacy legislation. International providers operating under the

European Union's General Data Protection Regulation (GDPR) were generally regarded as meeting standards that exceed South Africa's POPIA requirements, although practitioners were encouraged to review service agreements carefully rather than relying solely on vendor assurances.

### **Clinical Documentation as a Legal Safeguard**

Accurate, contemporaneous documentation remains one of the strongest protections against medico-legal claims. Whether records are handwritten, electronic, or AI-assisted, they should accurately reflect the clinical encounter and remain internally consistent.

The panel warned against making retrospective amendments to records unless appropriately documented, as later alterations may undermine the credibility of the practitioner during legal proceedings.

### **Rapid Technological Change Outpacing Regulation**

The session concluded by recognising that healthcare technology is evolving faster than the legal and regulatory frameworks governing its use. Artificial intelligence, electronic health records, cloud computing, and digital communication are becoming integral to modern clinical practice, yet clear legal precedents remain limited.

Healthcare practitioners therefore need to remain informed, exercise professional judgement, and adopt new technologies cautiously while ensuring compliance with existing ethical and legal obligations.

### **Overall Insights**

Several overarching insights emerged from the discussion:

Regulatory oversight and fraud prevention are necessary components of a sustainable healthcare system, but they must be balanced by procedural fairness and transparent communication.

Professional societies play a critical role in supporting practitioners, advocating for fair processes, and facilitating engagement with regulators and medical schemes.

Artificial intelligence should enhance, rather than replace, clinical practice. Responsibility for documentation, decision-making, and patient care always remains with the practitioner.

Robust clinical records, informed consent, and strong data governance are increasingly important as healthcare becomes more digitally integrated.

As technology and regulation continue to evolve, practitioners should remain engaged with professional guidance, participate in ongoing education, and adopt a proactive approach to medico-legal risk management.

Overall, the session reinforced that maintaining high standards of professionalism, documentation, communication, and governance remains the most effective strategy for reducing legal risk while delivering safe, patient-centred care.

### Additional insights raised during the discussion

|                                                                                                                                                          |                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| ◆ A complication should be managed clinically before it is managed legally.                                                                              | ◆ Families often become distressed when they feel ignored, excluded or not heard.                                                               |
| ◆ Practitioners should avoid language that implies something “went wrong” when the more accurate description is that a recognised complication occurred. | ◆ Open communication does not require speculation or admission of fault.                                                                        |
| ◆ The family should understand that the complication is being actively managed.                                                                          | ◆ A doctor’s relationship is with the patient, and disclosure to family must be handled carefully.                                              |
| ◆ A complaints pathway is useful because it gives patients somewhere to go before escalating externally.                                                 | ◆ Retrospective notes are acceptable if clearly identified as such and not used to alter the record.                                            |
| ◆ Private practitioners appear to face a high number of HPCSA complaints.                                                                                | ◆ Section 59 processes are legitimate in principle but can be experienced by practitioners as procedurally unfair, intimidating and disruptive. |

## KEY QUESTIONS & RESPONSES

### Q What should a practitioner do in the first 24 hours after an adverse event?

*The first priority is not a legal defence but the immediate clinical needs of the patient. The practitioner should ensure appropriate escalation, ICU admission where required, multidisciplinary support, imaging, blood products or interventional care as clinically indicated. Once the patient is stable, the doctor should communicate openly with the patient or family, avoid speculation, and notify the indemnifier at the earliest appropriate opportunity.*

### Q How should the doctor communicate with the family if the doctor is still operating on another patient?

*The panellists recognised that the doctor cannot be in two places at once. However, the family should receive a clear message that the doctor is aware of the complication, that appropriate care is being arranged, and that further information will be provided. It is acceptable to say that not all answers are available yet. The communication should not minimise the complication or suggest certainty where none exists.*

### Q Should the practitioner phone the indemnifier immediately, even late at night?

*Not necessarily. If the patient has been cared for and stabilised, and there is no immediate need for legal or emotional support, notification can take place the next day. However, practitioners should understand their own indemnity provider’s reporting requirements and should contact the indemnifier early enough to obtain guidance and preserve support.*

### Q Is a complication the same as negligence?

*No. The discussion made clear that a complication does not automatically mean negligence. Claims may arise not from the complication itself, but from failure to recognise it, failure to act appropriately, delayed escalation, poor documentation or inadequate communication.*

**Q How important is documentation after an adverse event?**

*Documentation was described as critical. Panellists advised that practitioners should record clinical reasoning, interventions, conversations with family, escalation steps and decisions taken. The notes should reflect what happened and why decisions were made.*

**Q Is a retrospective note acceptable?**

*Yes, provided it is clearly marked as retrospective, dated correctly, and not presented as a contemporaneous entry. The reason for the late entry should be clear. The concern is not that a retrospective note exists, but whether it appears to be an alteration or cover-up.*

**Q Should practices have a formal complaints process?**

*Yes, although panellists differed on how much this would reduce formal claims. A simple process, such as a clearly communicated email address or open-door policy, may provide patients with a route to raise concerns before escalating to the HPCSA, media or legal channels. It is not a substitute for direct clinical communication during a crisis.*

**Q Can the doctor speak freely to family members after an adverse event?**

*POPIA-related concerns were raised. Panellists suggested that the practitioner should take reasonable steps to identify who may appropriately receive information, avoid oversharing, and consider the patient's interests and consent where possible.*

**Q What is Section 59 of the Medical Schemes Act about?**

*The moderator explained that Section 59 relates to payment by medical schemes to providers, including payment timelines and the ability of schemes to recover money where services are alleged to have been fraudulently or incorrectly billed. The discussion linked Section 59 to fraud, waste, abuse and error investigations.*

**Q What concerns were raised about Section 59 investigations and audits?**

*Concerns included opaque processes, poor clinical understanding by administrators, unilateral implementation, lack of prior engagement, large retrospective recovery claims, coercive acknowledgements of debt, and the burden placed on practitioners who must keep working while defending themselves against audits.*

## PRACTICAL TAKEAWAYS

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>01</b></p> <p><b>Prioritise Patient Safety First</b></p> <p>Private practitioners should prioritise immediate patient safety after any adverse event and ensure escalation is timely and clinically appropriate.</p>                                 | <p><b>02</b></p> <p><b>Build a Clear Complaints Pathway</b></p> <p>Practices should build a clear, simple complaints pathway into their practice documentation and patient communication processes.</p>                           |
| <p><b>03</b></p> <p><b>Communicate Early with Patients</b></p> <p>Doctors should communicate early with patients or families after complications, even if the initial message is limited to what is known and what is being done.</p>                      | <p><b>04</b></p> <p><b>Document Reasoning, Not Just Actions</b></p> <p>Clinical notes should record not only what was done, but the reasoning, timing, escalation, communication and follow-up plan.</p>                          |
| <p><b>05</b></p> <p><b>Mark Retrospective Entries Clearly</b></p> <p>Retrospective entries should be clearly marked, dated and explained.</p>                                                                                                              | <p><b>06</b></p> <p><b>Know Your Indemnifier's Requirements</b></p> <p>Practitioners should know their indemnifier's notification requirements and should not wait until a formal claim arises before seeking guidance.</p>       |
| <p><b>07</b></p> <p><b>Review Informed Consent Documentation</b></p> <p>Practices should review informed consent documentation, especially for higher-risk procedures and situations where the doctor has limited prior relationship with the patient.</p> | <p><b>08</b></p> <p><b>Avoid Oversharing Patient Information</b></p> <p>Practitioners should be cautious about sharing patient information with family members and should take reasonable steps to avoid oversharing.</p>         |
| <p><b>09</b></p> <p><b>Seek Early Advice on Audits</b></p> <p>SAPPF members should be encouraged to seek early advice when they receive audit, verification or Section 59 correspondence.</p>                                                              | <p><b>10</b></p> <p><b>Develop a Follow-Up Resource</b></p> <p>It should be considered to develop a follow-up resource for members on adverse event communication, documentation, complaints handling and audit preparedness.</p> |

## RECOMMENDATIONS AND POLICY CONSIDERATIONS

- Develop a SAPPF member guidance note on managing adverse events in the first 24 hours, including clinical escalation, communication, documentation and indemnifier notification.
- Prepare a template or checklist for retrospective clinical notes that complies with the principles discussed in the session.
- Encourage member practices to implement a clear complaints process or open-door policy and include it in practice documentation.
- Consider a SAPPF briefing on confidentiality, POPIA and communication with family members after adverse events.

- Develop practical education for members on Section 59 audits, including how to respond to requests for records, coding explanations and recovery claims.
- Continue engagement with funders and administrators on procedural fairness, clinical review, mediation and transparent audit processes.
- Consider further SAPPF advocacy on the burden of medico-legal, administrative and funding-related work on private practitioners' time and remuneration.
- Explore a structured SAPPF resource on informed consent, especially where the practitioner has limited time to build a relationship with the patient before urgent or semi-urgent procedures.

## QUOTATIONS

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*“Complications occur at any stage.”*

*“A complication doesn't necessarily equate to negligence.”*

*“You can't be everything to everybody.”*

*“Care for the patient first.”*

*“The patient and their family need to know that they can come to you directly when there's a problem.”*

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