PRESENTATION TO THE COMPETITION COMMISSION ON THE HEALTH MARKET INQUIRY

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(1) It is well known that our healthcare has been said to be HOSPICENTRIC and as a result it is no wonder the highest cost of healthcare service is at the hospital level as confirmed by the Council for Medical Schemes report (CMS)

(2) The fact that specialist come in second should not come as a surprise and should not imply that they are overcharging as they are expected to be the ones consulting and treating patients at private hospital level and as such it is expected that they should consult more and thus earn consumerate income

(3) The fact that GPs earn only 6-7% should be seen as a sign of anomaly of our primary healthcare. GP services have been curtailed to an extent that patients have to visit the hospital and be seen by specialists more often than they should as GPs are restricted from seeing patients as benefits exhaust as early as midyear.

Prior to 2004

Before 2004 Medical Schemes, Hospitals and Medical Practitioners as well as well as other providers used to sit around the table to debate a reasonable tariff, standardised and acceptable to all parties. The missing party in this arrangement could have been the patient. This brought about tariff certainty for all involved

In 2003 this was ruled anticompetitive by the Competition Commission. Competitions was introduced and this competition meant that the sky was to limit. Anyone was to charge as they wish and the market will decide and any scheme will pay as they can and the patient will see to finish.

To illustrate, if a doctor did an appendectomy he can charge, say R20 000 another charges R3 000 and the two would compete in price about who's operation is cheaper. That is deemed to be competitive. The patient with an acute appendicitis is then encourage to choose the cheapest surgeon

The scenario above cannot apply to a patient who is unable to choose, such as a patient who has sustained multiple fractures from a motor vehicle accident. That person is at the mercy of whoever gets to treat him, whatever the price. Therein lies the problem with this ruling by the Competition Commission patients become the victim of the price. No standards No checks and balances, it's free for all except the patients. Patients are victims of a price havoc

After this ruling the following happened

(1) Medical practitioners have no limit, higher or lower as to what to charge

(2) Medical schemes pay different rates for similar services. Nothing obligates them to pay doctors the same amount. Patients occasionally may need to mortgage their homes to pay for their shortfall

(3) Patients are not aware of this new "empowerment''. Some cannot even possibly exercise it as they may be too sick to shop around the country for the cheapest doctor or hospital. They may even be in coma for that matter

EROSION OF PRIMARY HEALTHCARE

No wonder our healthcare system is hospicentric and consequently expensive with no standard and guidelines as already alluded to above. Hospitals are bound to make a killing (legally)

GPs can see many patients and render very cost-effective services at a primary level if they were allocated enough budget to avoid unnecessary referrals. The scenario at the moment is that medical schemes have eroded services that can be rendered by a GP ending up having such conditions referred to hospital

Examples are:

Early exhaustion of medical aid benefits, sometimes as early as April in the year. When a patient comes with follicular tonsillitis you end up referring to an ENT specialist at the hospital. The hospital must charge and the specialist must also charge both of them legally.

A stye (micro abscess of the of the eyelid) you refer to an ophthalmologist

A skin wart you refer to a dermatologist or a general surgeon

Do you still wonder why patients go to hospital? GPs are now forced not to do what they could do

Rural areas are serviced by mostly by GPs. They do caesarean sections, tonsillectomies, laparotomies, and later do that as private practitioners

The reality is they do it once experienced in such procedures. They do not murder their patients. The only condition being do not do it if you cannot as you can get into trouble for attempting to do a heart transplant with no skill

Influenza you end up referred to hospital as pneumonia once benefits are exhausted, as a GP may not be paid. But there are enough hospital and specialist benefits to treat such influenza.

Give more primary healthcare benefits so that you may reduce the cost by anything up to 30-40%

If you encourage referrals to hospitals the *status quo* remains

I am not surprised. I am surprised people are surprised.

Our conundrum therefor arises from

1. Lack of central structure to regulate fees in the private health sector.
2. Lack of coordination in the Acts or laws governing the different statutory bodies, e.g recent announce by HPCSA that patients must do their own authorizations and not the medical practitioners

3. A plethora of regulations from multiple medical schemes which at times become more of a burden than disease itself.
4. A wholesale of rules by everyone dictating how medicine should practice, e.g. A. Rule that would stop radiologists from doing pregnancy sonars after twelve weeks as well as a rule that restricts or stop GPs from doing X-Rays
5. Poor communities by schemes with their own members

RECOMMENDATIONS

1. There appears to be a need to establish a subdirectorate within the Department of Health that would dedicated to private healthcare that would exist beyondd the tenure of this task team. The composition of such a sub-directorate should made of all relevant stakeholders in private healthcare
2. General Practitioner consultations should trearted as a PMB to avoid early exhaustion of benefits
3. There is need to relax and expand the scope of general practice without making it an onerous exercise
4. The ruling of the Competition Commission needs to be repealed to allow for fee discussion supervised by persons with no vested interest
5. The structure proposed in the first recommendation should also be assigned a duty to study and cure defects in the Medical Schemes Act, Health Professions Act of South Africa, National Health and all other laws governing private healthcare with their corresponding rules and regulations