The Competition Commission
Health Market Inquiry
Trevenna Campus,
Block 2A, Fourth Floor
70 Meintjies Street
Sunnyside
PRETORIA
0002

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Attention: Stuart Murray

Clint Oellermann

Via Email: stuartm@compcom.co.za

clinto@healthinquiry.net

Dear Sirs

RE: TARIFF DETERMINATION – CALL FOR SEMINAR PARTICIPATION

I write to you on behalf of my client the Independent Practitioners Association Foundation.

Unfortunately we received the call for submissions relating to the above matter rather late but would appreciate the opportunity to respond and participate in the seminar.

The IPAF is a network management company for medical professionals[1] and a provider of peer review and profiling services to Funders. IPAF represents approximately 5500 General Practitioners in South Africa.

[1] Specifically in the instance of the IPAF –General practitioners.

1. **Collective Bargaining**

IPAF supports the call to return to collective bargaining but believes that specific legislation should be enacted which explicitly allows for exchange of information and resultant multilateral price negotiation between certain categories of healthcare professionals and funders. The private healthcare industry needs to operate in an environment of certainty and only legislation can now create the correct climate of certainty to take forward multilateral stakeholder negotiations.

IPAF agrees with the current practice of tariff determination as stated in paragraph 18 of the Commission's discussion document on Tariff determination. GP's especially have borne the brunt of the "*take it or leave it*" approach which has had the following effect on the GP profession:

- A steady decline in the total GP spend as a portion of total practitioner spend in healthcare. Currently less than 6% of the total payout in the medical aid system is paid for GP services.
- GP's have lost their role as gatekeeper and coordinator of care in the profession as medical scheme benefit design has switched the GPs out of the mainstream of medicine, and patients self-refer to specialists at inordinate costs to the system. Specialists likewise inter refer without referring the patients back to their GPs
- Regulation 8 combined with scheme plan design facilitating direct specialist referral, (and seen in the light of PMBs which can never expire provided Managed care principles and DSPs are utilized except in emergencies), have put the industry into a death spiral.
- An inability to attract young medical professionals into private practice. This is borne out by the average age of GP's in the private sector now being 57 years. Young medical professionals prefer to join the service of the State as

Medical Officers where they earn salaries in excess of what the average GP earns in private practice.

- RSA is thus on the precipice of a specialist driven healthcare system which will run out of money in the short term.

2. **Tariff determination between Funders and Practitioners**

IPAF disagrees with the statements in paragraphs 22 and 23 of the Commission's discussion document. Specialist networks are far easier to form than GP networks, as the numbers of specialists involved in these networks are relatively small to manage compared to GPs and the Funders already have an administrative network in place with established, IT systems, full-time employees' etc. who need to be hired to manage the network etc.

Smaller schemes are able to utilize the IPAF network or other networks and therefore they need not incur the cost of establishing their own network.

Doctor groupings too have established Doctor Networks, such as IPAF for GPs, and a collection of doctor run networks for specialists. These Specialist networks however concentrate on billing and practice management for their doctors, whereas IPAF concentrates on network management and peer profiling and review services, thereby aligning IPAF with quality assurance, and improved outcomes both in terms of process and outcomes measurement.

3. **Preliminary observations regarding Tariff Determination**

The Competition Commission decision, in its ruling against setting tariffs by the Medical Association of SA, in 2004 essentially took away the *"referee*" whereby

stakeholders and the HPCSA could align, enhance and even, in the case of the ceiling tariff set by the HPCSA, enforce their own tariff constraints in specific disciplines. After the Commission's decision neither the HPCSA nor professional organisations could intervene by setting a guideline or a ceiling tariff.

The introduction of PMB's added to the existing woes of the industry, as the majority of Specialist codes were located within the 270 PMB diagnosis and treatment pairs, whereas primary healthcare including preventative consultations with a GP, was not classified as a PMB.

The benefit design of schemes don't generally cater for the comprehensive funding of GP services, especially in the so called "*low cost options*" for which medical scheme members for the most part have to pay out of their pocket to see their GP. There are traditional plans which will pay for general GP consultations but at very low unsustainable rates to the GP, as these funds are drawn from the patient's day to day savings, which invariably runs out, and the patient is reticent to utilize as these same savings are available for physiotherapy, pharmaceuticals, dietetics, podiatry etc.

The current "*take it or leave it*" approach from medical schemes does suggest some form of parallel conduct between schemes as generally speaking GP's are afforded the same increase by most schemes which are ostensibly linked to CPIX. Schemes however benchmark their subscription increases annually against medical CPI and not CPIX.

GP's have had no bargaining power or countervailing power against the larger or even smaller schemes as they are unable to collectively bargain.

4. **Probable recommendations: Collective Bargaining and Price Regulation**

IPAF agrees that the tariff bargaining process should be hosted by a regulator and should be completely independent.

IPAF does not agree that the organisation should ultimately report to the Minister of Health ("MOH") as the MOH may in future become the largest purchaser of private healthcare services with the advent of NHI. This presents the MOH and NDOH with an inherent conflict of interest as one cannot sit as an active participant at the bargaining table and be the ultimate referee.

The Regulator should be created through an act of parliament and its decisions should be subject to review by the High Court. It could ultimately report to the Minister of Finance or the Treasury Department but preferably not to the Minister of Health, in isolation.

The governing body should be staffed by a combination of full-time employees (including medical professionals) and part-time elected stakeholder representatives serving the organisation on a rotational basis.

IPAF agrees that the Regulator should also be responsible for maintaining and upgrading equitable coding systems. New codes should be updated and adopted as and when the need arises. It is important to consult professionals from the specific discipline the code is ascribed to as they have the practical knowledge to understand the procedure performed or to be performed and what it entails.

We agree the organisation should be funded by a combination of taxes and industry levies.

IPAF does not believe that the organisation should have any additional responsibility for collation and analysis of data and practice profiling as this could place the organisation in a position where it has a conflict of interest.

Ad paragraph 33.1 Mutilateral negotiations alone will not resolve issues like PMB's, benefit design and inappropriate consultation of specialists;

Ad paragraph 33.2 Tariff guidelines should be (finally) determined by the multilateral bargaining forum representative of stakeholders;

Ad paragraph 33.3 Yes we agree certain categories of professionals should not be allowed to collectively bargain but it is inappropriate and incorrect to refer to them as "corporatised". No medical practice in South Africa is officially corporatized (corporate ownership) due to the HPCSA ethical rules for undesirable business practices, however there are significant organisations of GP's which are run by way of corporate involvement.

GP's should be allowed to collectively bargain through any association or organisation and IPAF specifically would like the ability to negotiate tariffs on behalf of its members.

Ad paragraph 34. We agree service providers should be able to charge less.

Ad paragraph 35. We agree that tariff's should be widely disseminated to the public.

Ad paragraph 36. We believe that the model used by the Medical Association of SA in the period prior to 2004 was appropriate albeit with numerous flaws pertaining to insufficient representation by GPs in this process. Coding was kept up to date, and a methodology existed to set the tariffs against coding, time, expertise and complexity of procedure. The HPCSA would then set its maximum ethical tariff at anything which was greater in value than 20% over the recommended MASA tariff. The philosophy behind this idea should be used again.

Ad paragraph 42.1 Over and above setting of tariffs the way to facilitate a phased transition from pure FFS models to models that include components of quality, process and outcome excellence is by way of performance based re-imbursements.

IPAF has pioneered this approach and has successfully implemented it in numerous medical funders whereby transparency is created for the practitioner on the cost generated by his practice taking into account quality and outcomes measurements to ascertain whether the cost was reasonable and achieved quality outcomes for the patient taking into account certain metrics.

Profiles based upon anonymized, washed, risk adjusted data per practitioner are produced and benchmarked against the cohort of all General Practitioners servicing the client scheme. Peer review is the utilized for outliers. During this peer review process, there may be unique factors identified specific to the practitioner's geographic region or patient profiles that may be driving specific costs that need to be taken into account.

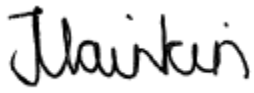
It is, however of critical importance not to place GP's in a worse position than they currently are by a model of tariff setting which terminates fee for service and introduces Alternative Reimbursement Models (including capitation) at a remuneration level which renders the GP's practice unsustainable. This would simply result in the continued inability of the private sector to attract GP's to the profession or existing GP's will relocate their practices abroad in jurisdictions where they are able to earn far more.

The GP profession is in urgent need of legislative intervention which will allow it some countervailing power in the healthcare market these interventions include the following:

- Reinstatement of the GP as coordinator of care;
- Legislation allowing GP's the right to collectively bargain;
- Review of benefit design of schemes
- Review of the PMB regulations, their open ended payment implications irrespective of tariffs charges, and the inclusion of primary healthcare into the list of PMBs
- An independent Regulator to host multilateral stakeholder negotiations on tariffs and to undertake and update coding of procedures;
- Re-introduction of an ethical ceiling tariff similar to what was in place pre-2004;
- A second independent Regulator to host quality metrics;
- Peer profiling and review must be compulsory across all professions linked to quality metrics;

- Funding of the Regulators should be partly by way of patient levy and in part by way of taxes;
- Any introduction of a tariff should still allow practitioners the ability to charge less or more that the negotiated tariff subject to an ethical ceiling tariff;
- Tariff introductions must be underpinned by costs studies so as not to render the GP practice unsustainable.

Yours Sincerely



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