Dear Mr. Oellermann

Re: SASA SUBMISSION ON THE PROVISIONAL FINAL REPORT

Thank you for receiving this submission from the South African Society of Anaesthesiologists (SASA) on behalf of the Health Market Inquiry (HMI) Panel.

Structure

This is an extremely extensive and important report. As such, SASA has given considerable attention to it and our submission is comprehensive, we believe. We have made every effort to be detailed in our submission and, where possible, to provide evidence in support of our submission, as requested by the HMI.

We have structured this submission into three major sections.

1. The first speaks specifically to the recommendations and the way forward.
2. The second section then speaks to the report findings concerning anaesthetists and SASA specifically.
3. The final section looks at the remainder of the report and gives input into some of the more specific issues not dealt with in either the recommendations or the statements about anaesthetists and SASA.
Introduction
Before we make any specific comments, SASA would like to thank the Panel and HMI staff for the considerable work they have put into this critical Inquiry. SASA agrees that there is much that can be improved in South African healthcare, including within the private sector. This report, and the processes within and flowing from it, provide an important opportunity to effect positive change.

Section 1 – Recommendations and Way Forward
SASA will provide detailed comments on the findings and the individual recommendations, especially where the Panel has proposed different options. While we may disagree with specific findings leading to the recommendations, and SASA will provide evidence in those instances, we believe that the remedies proposed are, as a whole, positive and appropriate for the future of the private healthcare market. SASA’s comments on the recommendations, as a result and for the most part, therefore speak primarily to how these recommendations can be enacted and what role SASA can play in supporting their implementation.

General Recommendations
SASA notes that the Panel recommends a holistic implementation of the recommendations, lest we find ourselves with partial solutions that may tend towards the creation of further market failures. SASA is in support of this approach. We note that some of the recommendations may be logistically more difficult to implement and that some may be difficult or burdensome on the practitioner. That noted, all of our comments on the recommendations speak to how these may be more effectively implemented and there is no recommendation within our own areas of expertise that we would argue should not be implemented.

Funder Recommendations
- Plan Simplification and Clarification – despite being directly involved in the healthcare sector, SASA members find the scheme and plan environment just as difficult to navigate,
both as patient advisors and as patients ourselves. Outside of patient (consumer) factors that aggravate the consequences of information asymmetry, the lack of clarity with regards to coverage, Prescribed Minimum Benefits (PMBs) and plan design further leads to an excessive administrative burden for practitioners who in majority seek to support the patient in their engagement with the funders. As such, SASA supports all and any recommendations to standardise, simplify and clarify.

- It is noted that there is a limited number of successful networks within the anaesthesia profession. SASA’s experience is that there has been a limited real attempt by schemes to establish such networks. We note here (and explained later herein) that SASA does not and has not engaged in any form of tariff negotiation with funders or administrators since the Competition Commission ruling of 2003. We deal with the HMI position and report on coding in the sector too. The failure of many funders or administrators to achieve effective Anaesthetic networks is universally one of either no real will to establish same or an inability of the fund to offer a network that is viable to sustain a practice in the private sector. SASA does not and has not advised its members on whether participation in any network is endorsed or not. In line with the HMI note when evaluating tariff publication in the current environment (pg 375, point 54), SASA agrees and has conducted itself entirely in accordance with suggesting its members consider all network agreements as the tariffs proposed by the funds for their unique practices. While SASA will make every effort to ensure the contracts offered to practitioners are legal and ethical, we encourage every practitioner to consider their individual practice and give proper consideration to such offers. Our member base is diverse in practice location and individual cost and other requirements. SASA has not considered its role as one of tariff suggestion, negotiation or otherwise since 2003. Without being permitted or willing to engage in any tariff discussions, SASA will support and advise any scheme seeking to establish a network. Evidence of SASA engagement with multiple stakeholders can be provided on request that shows both constructive engagement in advice on network establishment (with no tariff recommendations) as well as the

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Vice President | Dr. L Lasersohn  
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Chief Executive Officer | Ms. N Zimmelman  
National Secretary | Prof PJHL Fourie  
National Treasurer | Dr. S Chetty
establishment of alternative reimbursement models in the sector and in accordance with HPCSA ethical rules (see later).

- SASA notes that the HMI strongly recommends mechanisms to establish value-based networks and specifically those that move away from a Fee For Service (FFS) environment. SASA noted that few such current South African programmes appropriately addressed the value-based or patient care requirements of such models and, as a result, real patient harm has been experienced. Extensive details of these concerns were submitted to the Competition Commission in an effort to find a proactive way forward. This submission was, we were told, sent to the HMI for their deliberation, although no feedback was received. This submission was made on the 29\textsuperscript{th} March 2017, with an acknowledgement from Mr. Oellermann of receipt 3\textsuperscript{rd} April 2017, whereby we were informed that this would be shared with the Panel.

SASA understands that the competition commission historically does not dedicate time to evaluating or investigating demand side or purchaser side anti-competitive practices in the market place. SASA has, in the past, submitted particular complaints with respect to such anti-competitive practice and in particular with respect to global fee products. It remains curious to us that these practices, with direct negative impact on patients, have not been flagged to be evaluated to by the competition commission. We have stated in multiple fora that global fee products based on other OECD country design do not provide adequate patient protection in the South African setting. In those systems, participating practitioners are departmentally organised in majority (mostly employed), are able to easily articulate and protect patient care positions and are not subject to coercion, intra team power dynamics and resultant underserving forced by facilities or 3\textsuperscript{rd} party MCOs. SASA is able to provide evidence of all these negative effects on request with current market products. It is important to appreciate that while competition is healthy for “business”, unchecked, unregulated and unmonitored
environments lend themselves to the pursuit of “for profit” agendas at patient cost.

Despite having established a Position Statement on the effective establishment of Alternative Reimbursement Models (ARMs) as far back as June 2015, efforts by SASA to ensure a more patient-centric approach to ARMs by funders and third-party providers did not achieve any success. As SASA did not want to prevent the implementation of such ARM networks, but simply sought to ensure patient care is not compromised, we designed and created a societally-driven mechanism to achieve the objectives to which we all agree – enhanced teamwork, enhanced value and outcomes measurement and enhanced accountability. Discovery has now offered an arthroplasty network based on this mechanism and Metropolitan Health has proposed this as part of their tender to provide maternal care under the recent NHI Tender Request. Medscheme and other funders are likely to adopt and roll out these designed ARMs in the near future.

This mechanism requires accountability and peer review, the collection and sharing of outcomes measures and some risk sharing on costs, based on a fixed fee not related to additional procedures or patient risks being encountered. While we do not have the exact figures, as tariffs were never part of the discussion, we believe the rate currently being offered by Discovery as part of this network may be lower than some other rates being offered, such as by ICPS.

While it took 2 years to complete from design to implementation taking competition law, medical schemes law and contract law into account, within a relatively short time from introduction (mid-July to mid-August) over 300 anaesthetists have confirmed participation in this more patient-centred ARM. Those who had participated in models that they report paid in excess of that offered by Discovery Health, have opted to take a lesser fee in favour of ethical care and peer review to enable better outcomes. This model and the practitioner response shows SASA’s proactive support for the establishment of ARMs and ARM-based networks, the support and willingness of anaesthetists to
participate in ethical and patient-centred models of care and demonstrates how such creative solutions can gain traction in the healthcare market.

SASA is very willing to share, should the Panel wish, the original submission to the Competition Commission and copies of the SASA Event-Based Contract between the clinician and the Administrative Entity, as well as the annexures and the supporting contract for peer review and outcomes measurement between the Society and the Administrative Entity. The details of the service to be provided are contained within the annexures for two reasons. Firstly, this makes it possible for the contracts to add annexures for further episodic events relatively easily, extending the network to additional procedures. Secondly, the annexures detail the tariff negotiated between the funder and practitioner. This detail is of no relevance to SASA and we do not wish to engage in or see what the practitioner has contracted in this respect. The annexures, therefore, allow SASA to support the best practice care components of the contract without being involved in any way with the tariff components.

In conclusion of this recommendation, not only is SASA supportive of efforts to drive value-based contracts based on alternative reimbursement models, but we have invested significant time, member funds and efforts to collaboratively establish these networks. Specifically with reference to Point 218.2 (pg 349) SASA draws the attention of the HMI to clinical and practice guidelines revised every 5 years by SASA (last revision released 2018) with a clear indication of the leadership provided by SASA and its participating academics that provides guidance on evidence based care and treatment protocols for the discipline of anaesthesia. These guidelines are complemented by many other special interest guidelines within the discipline of anaesthesia (e.g. Sedation guidelines and others). Furthermore SASA Council, already in 2016, initiated guideline development for specific event based anaesthesia starting with arthroplasty for hips and knees in anticipation of the Event Based Contract designed by SASA. The ‘failure” referenced is certainly not throughout all specialties.
• SASA also notes that the HMI recommends that schemes be required to report to the Council for Medical Schemes (CMS) on the savings generated through ARM-based contracts and efforts and that the CMS be obliged to publish this information. SASA supports this recommendation, but suggests that the reports be required to provide information on the quality metrics and mechanisms used to ensure patient care. The “outcomes and value” reported must consider all 6 quality metrics (as defined by the Institute for Healthcare Improvement (IHI), one of which relates directly to cost and the reporting thereto). We believe that a purely financially focused reporting and oversight perspective will drive some unintended consequences, as we have reported in the abovementioned submission.

SASA notes that there are currently a number of different proposed definitions of Prescribed Minimum Benefits, with some potential conflicts between them. For example, the current Medical Schemes Act and this HMI report speak to a need to provide for catastrophic care and in-hospital cover, with the HMI report also seeking to ensure more preventative measures. The current Medical Schemes Amendment Bill speaks to the provision of an essential care service benefit, which also focuses on greater preventative and primary healthcare, but may not provide catastrophic cover. SASA notes and agrees that it is the responsibility of the CMS to drive the stakeholder engagement to revise the PMBs. SASA agrees that there is an urgent need to revise these PMBs and has committed to the process of engagement. The SASA CEO, Ms. Natalie Zimmelman is one of the appointed provider stakeholders on the PMB Advisory Committee. SASA also notes that the Society does not have an opinion on what is finally included or excluded from the PMBs, although we do support a less hospital-centric and more preventative model. We believe that certainty and clarity on what is and is not included, together with a rational process, based on the South African disease burden, for deciding the inclusions and exclusions are far more important. Our contributions shall focus on input into these processes and then, through our Education Business Unit, to give input into best practice treatment protocols for the procedures included, once decided.
Supply-Side Regulator of Health (SSRH)

SASA is fully in support of the establishment of this body, together with all four divisions that are recommended be housed within this central regulator. We agree that the lack of a central view and oversight has enhanced the fragmentation within the healthcare sector and led to a lack of coordinated and rational decision-making. This fragmentation is not only bad for the patient, but is also overly burdensome to practitioners. SASA believes that not only are the recommended regulations proposed for practitioners reasonable, but that they will also reduce some of the burdens the practitioner now faces in this fragmented market and allow the practitioner to more easily focus on providing effective healthcare. Many of the recommendations within this are ones that SASA has long been requesting. Further comments on the various recommendations within the proposed SSRH now follow.

- Mechanism of establishment – SASA notes the proposed mechanism for the establishment of this critical entity being enabled through the National Health Act with a Board appointed by the Minister. SASA further notes the emphasis the HMI places on the independence of this entity. SASA notes the functional problems experienced with the HPCSA, as well as concerns about the independence and effective capacitation of many entities with Boards appointed by the Minister and even further notes the Minister’s own statements with regards his impartiality, or lack thereof, at the publication of this report. Given these concerns, SASA suggests that the same mechanism proposed for the establishment of the Outcomes Measurement and Reporting Organisation (OMRO), as defined in Chapter 10, be used for the establishment of the SSRH. Namely, that the President appoint the Board, with input from a multi-party parliamentary committee.

- SASA notes the recommendation for greater hospital licensing processes and for facility practice numbers to be enshrined in this process. This affects practitioners only to the extent that additional practitioner information forms part of this process. SASA sees
SASA is especially supportive of the facility information requirements extending to both the public and private sectors. There is a considerable lack of information on the perioperative environment, which certainly impacts patient care and effective planning.

SASA also notes the recommendations with regard practitioner licensing. SASA would specifically like to thank the Panel for addressing this specific concern raised by us.

On the practice numbering mechanisms, we note and support the recommendations that the practice number be uniquely allocated to one person and that this number be for life. We also note that the practice number should reference important information such as discipline, part or full-time and sector. SASA would be very supportive of this. However, we note that even disciplines may change more than once in a lifetime (note the comments on cardiologists and gastroenterologists practicing under their physician numbers and the case of obstetricians reverting to general practice). The practicality of the number referencing this important information while also remaining relatively stable are, thus, possibly conflictual. We would propose the following:

- The practice number remain stable for life and never changes.
- With a change in status (e.g. specialty acquisition) that a prefix of suffix number be changed to signal the affiliation to that specialty or discipline.
- That in the event that a practitioner belongs to an employed entity or group
practice that a second number be submitted per invoice (as suggested by the HMI recommendation) but that this number would never result in reimbursement without the individual’s number reflecting and being captured. At present reimbursement does occur and compromises data integrity.

- We do note that licensing mechanisms are the primary recommendation within the healthcare capacity planning function of the SSRH. SASA would like to strongly recommend that an additional function be added to this specific unit of the SSRH – that of skills development planning. SASA does note the responsibility for this already enshrined in the role of the National Department of Health, as well as the information requirements to this affect allocated to the CMS. The development of the appropriate skills for the country must be viewed as a whole, with both public and private sectors taken into account. The right skills, of the right disciplines, at the appropriate levels must be evaluated together with both incentives and barriers to the supply of these skills to our more rural communities in both the public and private sectors. The need for such a holistic perspective suggests the need to coordinate this within the SSRH and not through different entities carrying different responsibilities. SASA would argue that the SSRH is a tremendous opportunity to address a significant issue in healthcare.

- SASA does note the HMI findings on Supplier Induced Demand (SID) in the private sector. As you are aware, SASA is strongly of the opinion that there is a very real scarcity of anaesthesia skills in the country and that this is one of the key drivers for the lack of volume-based network success by the funders. We would argue that the evidence in respect of SID is not uniformly strong with many assumptions and not easily translated to all disciplines, and that we can produce evidence as to the scarcity of skills in this discipline and under-servicing of the population. The repeated reference and assumption in the HMI provisional final report of the “utilisation of capacity in the private sector” to service the public sector makes clear the belief that there exists massive capacity in the private sector. This capacity is variable regionally but unlikely
to translate into a massive human resource gain as may be suggested by the report. SASA has submitted what its member responses were in relation to time available to provide additional services to the patient population. That said, we do not believe it is necessary to counter this finding, as, regardless of ones’ view as to the over-supply or scarcity of skills, the remedy is likely the same – the establishment of a rational, central and carefully constructed workforce development plan. The SASA Council, with the support of the SASA Public Sector Business Unit and SASA Education Business Unit, is already working hard to propose and find mechanisms to support the development and delivery of an appropriate workforce plan for the country. We would like this to be housed within the context of the broader healthcare sector and engage with all stakeholders to realise a rational plan for the country. SASA argues that the recommended SSRH be an ideal entity to drive this.

- SASA strongly supports the housing of a coding authority within the SSRH. We further support the recommendation of a standardised coding system enabled and maintained by the SSRH. We note that the HMI report describes coding systems “integral to adoption of provider payment systems and essential to a well-functioning healthcare system – essentially a public good” in the recommendations in contrast to describing the publication of coding guidelines as anti-competitive in the report. We understand the principle highlighted in the latter although we express our disagreement in the view across the board of all societal conduct as it relates to coding to date. We address this issue later in our submission. We are very happy to be guided by the principles and structures of the recommended unit to modernise and continually align coding with best practice – something that we have constantly strived for with only some recognition.

**Tariff Determination**

SASA notes that anaesthetists are overwhelmingly in favour of price benchmarking and are also not averse to maximum prices that are reasonably set. The current vacuum in this respect is also not good for practitioners and is a market failure we have long been
asking to be addressed. As such, we support the proposal to have a rational tariff setting process through the SSRH.

- The HMI report offers two alternate models to achieve this. I am sure the Panel would not be surprised to hear that SASA favours the second option, whereby the parties reach a negotiated agreement within a set of terms and references published by the SSRH unit responsible. While both models have a compulsory and tight arbitrator system in place, our experience of regulatory oversight failures and lack of effective processes in this regard leads us to believe that a negotiated settlement is more likely to expedite certainty to the market and result in fewer challenges. The SSRH driven terms of reference will still set the parameters within which parties must reach agreement.

- While SASA has some concerns about these terms of reference, most centre on the practicality of these and not the principles underpinning the recommendations for having such a terms of reference. As such, it would be premature to comment until and unless such terms of reference are issued and we have concerns with the details therein.

- SASA takes note that the HMI is not recommending a reversion to the previous bargaining mechanisms and is cognizant that the recommended options are not the same as the pre-Competition Commission ruling in this regard. As noted above, we are not averse to the principled changes to the process. We do also note that the professional associations/societies are perceived to be acting anti-competitively and collusively. SASA will strongly contest the unfounded allegations of the Panel in our regard in Section 2 of this submission. That notwithstanding, there is no intimation that the limitations placed on professional associations will be amended for future processes. In both models of tariff determination, registered practitioners are able to have their
representatives engage on their behalf. Would the professional associations and, in this case, specifically SASA, be permitted to be the appointed representatives? If not, who else would be permitted to play this role and how would they then not be behaving collusively, if acting to represent more than one practitioner? Both proposed models recognise that it is not practical for individual practitioners to each negotiate.

HPCSA Ethical Rules
SASA notes the comments of the HMI Panel about the rigidity of the HPCSA Ethical Rules and certainly agrees that there has been ineffective and uneven implementation, with varying interpretations. This is, to us, an indication of a current lack of capacity to implement a more nuanced, innovative and patient-centric oversight role. It is true that the current Rules and application thereof are a blunt instrument.

When developing the societally driven ARM mechanism, SASA looked at all the instances where patient harm had occurred, what unintended consequences were likely in the South African private healthcare sector, and what in the model had either incentivised or permitted that harm to occur. In doing so, SASA realized the value of most of the Ethical Rules. SASA is, thus, concerned that loosening the Ethical Rules to allow for greater innovation where the regulatory capacity is insufficient to identify and prevent models that may harm the patient could have unintended consequences. It is important to appreciate that the local operational healthcare environment is unique and developed within the current framework. We lack the sophistication and regulatory oversight and policing that exists in the comparator OECD countries. This lack has and will continue to result in patient harm if ethical rules in their true sense are dispensed with.

That said, the current status quo is not the solution either. As shown by the SASA ARM mechanism, as well as effective population and disease management models such as offered by PPO Serve, there are innovations that can avoid perverse incentivisation. SASA will continue
to work hard to support such models, assist the HPCSA by reporting bad practice and do all within its power to enable the HPCSA in the implementation of its oversight role. Certainly guidelines of the HPCSA should be reviewed and robustly reconsidered and revised in accordance with the mandate of protecting the public and guiding the professions. Where innovation is required and patient harm can be avoided (ethically first and financially second) this must trigger revision of specific rules. The HMI has acknowledged the unintended consequences that may present with employment. Unintended consequences may too be realized with ill thought through revision of the HPCSA ethical rules mentioned in the recommendations as they relate to ARMs. There is a clear immaturity in the healthcare sector with respect to “practitioner contracting” both between practitioners and between other juristic entities and practitioners. Amendments to Rules 8 and 8A and the policing thereof, Sub rules 7(4) and (5) and 18 should therefore be well considered before revision. We suggest that further resources are allocated in the event of such rule amendments to the HPCSA or SSRH to ensure these rules are actively monitored and policed ensuring patient underservicing and harm, practitioner exploitation, coercion and perverse incentivization are not realized. SASA is available to engage further regarding this matter should it be necessary. We agree with the recommendations regarding rule 23A.

When patient care is viewed as the starting point for such innovation, as opposed to cost saving alone, SASA believes that quality (broadly defined to incorporate the critical efficiency measures) programmes can be identified. SASA also believes that professional associations such as ourselves have an important role to play in this regard, specifically in terms of defining best practice, peer review and outcomes measurement. SASA has long published Clinical Guidelines (referenced earlier) in support of this role, has always engaged in peer review (and are even strengthening this role) and have invested significantly in Safe Surgery SA over the past ten years to facilitate outcomes measurement. We have been, and continue to be, willing to take on these responsibilities.
Outcome Measurement and Reporting

SASA made a separate submission to the HMI in response to the discussion paper issued on this subject and participated in the seminar. This specific submission is attached here, as no reference was made to this submission or the efforts of SASA and Safe Surgery South Africa (SSSA) in the provisional report. This is despite the considerable alignment between the recommendations of the HMI Panel and the efforts SASA and SSSA are already making. As expected, SASA is fully in support of ALL the recommendations with regards the establishing of the Outcomes Measurement and Reporting Organisation (OMRO) and the phased implementation.

SASA does note that the recommendations in Chapter 9 in terms of the establishment of OMRO differ from the recommendations in Chapter 10. SASA strongly supports the mechanisms proposed in Chapter 9, rather than as summarized in Chapter 10.

Medical Practitioner Training

SASA also notes its strong support for the proposed amendments to the medical syllabus. SASA is already looking to send future leaders from within the profession on Health Technology Assessment programmes, as well as already hosts a number of personal financial management and practice management workshops. We emphasize cost-conscious practice of medicine in both the public and private sectors and have an issued position statement in this regard. An awareness of these issues from the outset will certainly add value to the healthcare sector.
Section 2 – Specific Findings and Comments about Anaesthesia and SASA

This section is in response to direct references to SASA in the HMI report only. This is with particular reference to points 93, 112, 194, 195, 196, 197, 198 and 199 of Chapter 7 only. We note for later reference that SASA has expended much time and effort and remains a volunteer association.

As noted previously, The South African Society of Anaesthesiologists (SASA) is a professional body representing the interests in excess of 90% of the specialist anaesthesiologists and anaesthetists working in South Africa’s public and private healthcare sectors.

SASA and its member clinicians view ourselves as allies of all those in the healthcare sector who are in pursuit of quality and sustainable healthcare delivery for all South Africans including the patients we interact with and treat. At any time, we too are subject to the same conditions and treatment we prescribe and are cognizant of this. Specifically and importantly improving healthcare access and delivery in a responsible manner that ensures improvement and not degradation of resources, access and quality.

We note with particular concern that many of these comments and then the subsequent recommendation in Point 200 have been tabled post SASA’s presentation and answers to questions at the public hearing held 24th February 2016, a meeting held on 19th January 2018 and a written submission dated 19th February 2018. All these issues were well ventilated with clear explanations provided to the Panel. SASA, without further insight from the panel, is unable to interrogate the reasons (more fully interrogated hereunder) why the compilers of the report have ignored both verbal and written submissions that clearly explain the issues raised in these specific points of the report. To discuss each issue more fully:

Reference point 93. from the provisional report:
93. For example, Surgicom’s (a surgeon management group) functions include “Ongoing contact with the funding industry to attempt to achieve an appropriate level of remuneration, and to
establish a strong voice when decisions are made” and “facilitates the consolidation of surgical claims data to negotiate coding and reimbursement with Medical Schemes”. Similarly, the South African Society of Anaesthetists (SASA) states that it continuously engages in tariff negotiations on behalf of its members and that its benchmark studies on private practice costs resulted in substantial improvement in remuneration to its members (our emphasis).

The reference from where the HMI panel quotes “reference point 93.” is not detailed in your report. The closest reference to this quoted reference in the provisional report is on the SASA website under “Member Benefits”. The website states as follows:

“SASA’s PPBU works with energy and commitment on enhancing the voice and recognition of the anaesthesia profession in the private sector. When this was permitted in law, we were the first society to benchmark private practice costs and, as a result, affected substantial remuneration improvement for all anaesthesiologists in private practice (our emphasis). SASA’s coding and ethical billing manuals streamline practice administration in the private sector and give patients and funders the benefit of coding predictability.”

SASA would firstly like to specifically and categorically state that it does not and has not participated in “continuous engagement in tariff negotiations” with any party or stakeholder in the healthcare sector outside of legislated participative engagements with the department of health or its designated representative (the Council for Medical Schemes) – either pre or post 2003.

In our presentation at the public hearing on 24th February 2016, in a follow up email to the panel with attached documentation on the 14th March 2016, and again in a formal meeting between the HMI panel and SASA representatives on 19th January 2018, specific detail has been disclosed as to the nature and extent of “negotiations” that took place through the legislated processes of the National Department of Health regarding determination of the National Health Reference Price List. To repeat these explanations:
While the legal matter regarding NHRPL was initiated in 2006 involving the National Department of Health and other healthcare sector interested and affected parties. This was only concluded in 2010. In 2008, the National Department of Health, through the CMS, requested parties to submit practice cost and other data supporting appropriate NHRPL tariffs to be set by the National Department of Health. Within this framework and as required by the process, many different stakeholders submitted data in support of evidence-based determination of practice costs that would then inform a determination of a reasonable tariff to be published by the National Department of Health as a NHRPL tariff. SASA embarked on and submitted such practice cost analysis and data (these reports submitted to the HMI as requested at the public hearing of 24th February 2016) as required by this process. It was then through this process that the CMS reached a conclusion in 2009 that the tariff published should reasonably be adjusted upward (in the region of 40%). This was not a collusive act between healthcare sector stakeholders but within a stipulated regulated process and as called for and required by the department of health. As a result of this particular process, and not an anti-competitive exercise as suggested by the HMI Panel, the CMS suggestion that an increase in tariff of the NHRPL for anaesthesiology was warranted, SASA effectively “affected substantial remuneration improvement for all anaesthesiologists in private practice”. Although the 2009 findings by the CMS could not be implemented in 2010 as a result of Judge Ebersohn’s judgement in the case that set aside NHRPL as determined from 2006 when the case was undertaken, some schemes opted to vary phase in these increases over the following years. This, again, was not a collusive act between SASA and each scheme but rather a scheme decision to implement a tariff for reasons they would best be positioned to explain.

Of course, SASA did express its opinion that the agreement of the CMS and other participants to increase the base NHRPL tariff for anaesthesia based on evidence based representations should be considered for the sustainability of the profession as a whole.
Points 194 and 195

194. Anaesthetists are specialists who provide anaesthesia to patients for operations and procedures. They are doctors who have chosen after qualifying to undertake postgraduate specialist training. While usually in support of surgeons, they also work in intensive care medicine and pain management.

It is important to note and as explained in our prior written submissions to the HMI Panel, not all anaesthetists are specialists. This is further highlighted in our survey conducted among our members that has been shared with the Panel.

195. Anaesthetists provide services based on requests from other providers. They are likely to work in group practices and are one of the specialities identified in the TOR as driving increased expenditure. Our analysis illustrates that, on average, claims costs generated by anaesthetists have increased by 9.51% per year over the five years from 2010 to 2014. The attribution analysis found that 3.51% of the claim cost increases is unexplained and cannot be attributed to factors such as the age, gender, and wellness of the patient being treated. (Point 165. In the prior HMI Practitioners Report)

This particular point is concerning given the effort and time the SASA and its volunteer representatives have devoted to addressing and explaining these concerns to the HMI – both at the meeting of 19th January 2018 and in the written submission on the Practitioners Report – Our submission made on 19th February 2018.

The meeting held at the Competition Commission offices (19th January 2018) was convened to discuss the SASA application to have access to the HMI data room. This request was made by SASA as we were of the opinion that the 3.51% increase deemed to be “unexplained” was likely easily explained if the data submitted were interrogated with insight into the changes in the
sector over the period interrogated. The HMI Panel, understandably, wished to meet to decide if access to the data room was necessary. This decision would be made dependent on the reasons given by SASA as to why access was required and whether the HMI panel, after discussion, deemed such access to be necessary to allow for a submission to be made.

SASA representation included Dr Japie Marais, Dr Lance Lasersohn and the SASA appointed actuarial representative Mr Tienie Stander from TCD Outcomes Research. We do not have all the names of those present from the HMI panel, but those present included Mr Clint Oellermann, Prof Sharon Fonn, “Adam” an actuary from WTW and an HMI attorney. While we do not have a transcript of the meeting that took place over a period of approximately 80 minutes, and are hopeful minutes or a transcript is available from the HMI, our understanding at the conclusion and a copy of our notes taken contemporaneously on the day:

“At this point Clint Oellermann asked, in light of them accepting these arguments verbally, but that a submission in writing would need to take place which they will ensure is well understood and then meet us if necessary, if we still require access. We explained that the intention to access was based on an assumption that WE would have to prove our arguments. On the basis that they would do the work based on our submission AND that the data itself would already have been processed (we would not get access to RAW data) we said we would be happy to not access the data room and ensure we submit our arguments.”

We invite the HMI to review our submission from the 19th of February 2018 and hereby attach.

During this meeting and again in our written submission, reasons for these “unexplained” increases in anaesthetic costs included:

- Explanation why “age and wellness” of the patient could not as easily be “controlled” for when compared to other specialties and code reporting as well as how such statistical “control” utilised for other international coding structures may not translate accurately for the South African coding structure.
• The variably applied “corrective tariff” through the process outlined earlier with the National Department of Health and CMS.
• The introduction and variable recognition and remuneration by Medical Schemes of new codes for anaesthesia. These code introductions brought code unit recognition in line with internationally accepted norms and did not reflect an increase outside of such accepted norms. These codes are still variably funded and accepted by different schemes. The introduction of the new codes in late 2011 and acceptance of these by some schemes in 2012 certainly explain the notable “spike” observed in 2012.
• The impact of new technology in anaesthetic practice as well as the impact of guidelines that provide membership with ethical rules around code reporting. One example (as elucidated in the submission) would be the introduction of ultrasound as a standard of practice where anaesthetists are required to develop skills to apply ultrasound in the placement of invasive lines and nerve blocks. This requirement being a standard, and a medico-legal requirement too, results in an increase cost of care (time taken to perform the ultrasound, equipment costs not always provided by facilities and professional costs that would otherwise be incurred by a radiologist for example).
• Scheme reporting on billed and not reimbursed tariff – the HMI assumption was that a shortfall would always be covered as an “out of pocket payment”. We explained, in both for a, that this was not the case as in many instances billed amounts were discounted to scheme reimbursed tariffs. Over the same period during the introduction and development of the Society and its guidelines, members were encouraged to bill a uniform tariff in line with the Consumer Protection Act and the rules of the HPCSA.
• The failure of schemes to report on a granular level as to the anaesthesia services delivered but only per procedure item results in a skewed analysis that does not accurately reflect either the time taken, or services delivered that is easily identified by codes reported per invoice submitted.

It is concerning that despite these verbal and written submissions, the HMI Panel makes no comment in respect of the explanations, did not interact further with SASA in the case of
disagreement with these explanations, but indicated at the meeting of the 19th January 2018 that provided written submission was made, the verbally articulated explanations were plausible and would be further interrogated. In the event that disagreement was then reached, SASA should reasonably have been afforded access to the HMI data room to ensure the HMI report was factual – above CPI increases that are explainable should not be reported as “unexplained”. Some indication of what was submitted and either proven and accepted, or rejected with a reason, should either have been communicated to SASA prior to the final report or included in the final report. For the final report to remain exactly the same, with no acknowledgement of the content of the engagement (albeit an acknowledgement of the engagement) seems to be against the principles “the requirements for procedural fairness” (Chapter 1, page 15) as outlined in the HMI report.

As the panel of the HMI would be aware, post the publication and omission of SASA comments or interrogation as to the applicability and integrity of the data and assertions submitted, SASA applied for access to the HMI established data room. As at our face to face meeting, we discovered through the interaction that the data itself had been subject to processing and we would not be able to access raw data, we remained concerned prior to access that the explanatory power of the data available for access would be limited. With limited time and delays with affording access, we had no option but to attempt to find evidence for our assertions as made in our submission.

Unfortunately, as expected the data accessed was heavily processed and lacked the data integrity and detail required to test our assertions. The visit by our appointed representatives was, at least, confirmatory that the analysts were unlikely to have been in a reasonable position to rework the data to prove or disprove our assertions had they indeed been asked to do so (which should have occurred post our submission in alignment with procedural fairness).

Our representatives’ report indicated that much of the data that would allow for easy explanation of cost increases in the sector with respect to anaesthesia are simply not reported.
in the data available. For example our advisors report that “Modifiers were not captured in the data” available, “data could not be aggregated per scheme as the mapping to the scheme codes was not available.”, “ICD-10 codes were not directly available in the data” and “only one procedure or diagnostic code was available per claim line”. This experience alone should indicate to the HMI panel that reporting unexplained increases post our submission and without being able to rework the data should prompt further investigation and not allow for conclusions to be reached without considering same.

As SASA was not prepared to accept a situation where the “unexplained” increase above CPI could, in fact, be explained but is simply ignored, we sought to obtain data to either validate or refute our assertions.

In alignment with “Supplementary Guideline No.2 on the management of access to Confidential Information submitted to the Health Market Inquiry” point 9:

*Any person who seeks access to confidential information for purposes of the Inquiry, and wishes to obtain such access by way of the framework provided by this Guideline, should in the first instance approach the Inquiry Director in that regard. Persons seeking access are not, however, precluded from approaching or negotiating with submitters directly* (our emphasis).

With extremely limited time, SASA approached stakeholders in the market to attempt to provide further evidentiary insight and to test the voracity of our claims in our submission.

We submit the following data obtained under conditions of a non-disclosure agreement to protect schemes, administrators and member data.

The data represents aggregated data from an administrator of open and restricted schemes of the privately funded market.

We would like to therefore reference the points in our submission that explains the “unexplained” increase above CPI.
Age and Wellness

This is an explanation why “age and wellness” of the patient could not as easily be “controlled” for when compared to other specialties and code reporting, as well as how such statistical “control” utilised for other international coding structures may not translate accurately for the South African coding structure.

As explained prior, while reporting of codes by surgeons for procedures would remain uniform per procedure (they may report multiple codes) and so too for other disciplines reporting for in-hospital events, the reported anaesthetic codes may differ vastly for the same procedure or event, dependent on age, co-morbidities and other factors that influence the conduct of anaesthesia. This occurrence is variable among many coding structures where some coding structures report modifiers and procedural interventions separately, others are included in the complexity of the procedure reported and others may have features of both. Furthermore we have highlighted that the anaesthetic invoice may include post-operative care for varying durations. Add to this that in the South African Coding system anaesthetists are required to report one (1) procedure code of highest value (not more than one as is permitted for surgical and other disciplines), it is very difficult to interrogate data and “control for items such as age and co-morbidities”. These factors may result in massive variability not in line with expected variability in other disciplines invoicing. We further reference you to figure 8.14 of the HMI report indicating significant correlation between age and co-morbidities to ICU admission which would be further likely when undergoing surgical procedures (and not necessarily SID).

Figure 3,8 AGGREGATE CHANGE IN THE DEMOGRAPHIC STRUCTURE OF MEDICAL SCHEMES FROM 2002 TO 2016 highlights the clear increase in the demographic of patients from 45 to 75+ years of age. While argument can be made that the percentage is small, there is no debate that spend increases with increasing age of population, that anaesthesia intervention and cost increases as a result of age related risk of anaesthesia and associated required interventions to enhance safety, and the likelihood of post-operative increased level of care is higher.
The following procedure codes were interrogated in the data made available for review over the period 2010 to 2014 in an effort to mirror the period evaluated by the HMI:

**Procedure codes considered**
- RA0304 - Major debridement of wound, sloughectomy or secondary suture
- RA0614 - Arthroplasty: Debridement large joints
- RA0637 - Hip: Total replacement
- RA0646 - Knee: Total replacement
- RA1127 – Tracheotomy
- RA1761 – Cholecystectomy
- RA2253 - Prostatectomy: Perineal: Radical
- RA5760 - Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level

To illustrate the variability of cost we opted to look at the 2014 variability in invoiced costs for anaesthesia invoices for these codes reported as the principal procedure codes (anaesthesia can only report one procedure code) with the following results grouped by quartiles:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Q1</th>
<th>Median</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA0304</td>
<td>1,878</td>
<td>2,822</td>
<td>4,537</td>
</tr>
<tr>
<td>RA0614</td>
<td>2,342</td>
<td>3,543</td>
<td>5,818</td>
</tr>
<tr>
<td>RA0637</td>
<td>5,049</td>
<td>7,031</td>
<td>9,199</td>
</tr>
<tr>
<td>RA0646</td>
<td>4,800</td>
<td>6,438</td>
<td>8,521</td>
</tr>
<tr>
<td>RA1127</td>
<td>4,444</td>
<td>11,000</td>
<td>23,418</td>
</tr>
<tr>
<td>RA1761</td>
<td>2,331</td>
<td>3,302</td>
<td>4,593</td>
</tr>
<tr>
<td>RA2253</td>
<td>5,063</td>
<td>7,464</td>
<td>9,870</td>
</tr>
<tr>
<td>RA5760</td>
<td>5,090</td>
<td>7,707</td>
<td>11,366</td>
</tr>
</tbody>
</table>

It is evident from this dataset that there is massive variability in the cost per event for these reported codes for anaesthesia – this owing to variability in duration and type of procedure (despite the same description), interventions and modifiers required per patient and the
possibility of ICU care and reporting of these codes on the same invoice.

Age and wellness do not take these variables into account, and nor do they take the variability or intervention and code reporting into account in a South African Coding model. The other factors described below would then aggravate the potential for an increase not explained by these factors and CPI alone.

Co-Morbidities
We then considered the interrogation of the above codes over the same period as they may be reported with the code 0018 – a body mass index of greater than 35.0 with the following data set result:
# South African Society of Anaesthetologists

**Official Group of SAMA**

**Association Not For Gain**

**T:** +27 (0) 86 010 3137 (toll free)  
**T:** +27 (0) 31 368 2530  
**F:** +27 (0) 86 242 9804  
**E:** sasa@sasaweb.com  
**PO Box 22511, Glenashley, 4022, South Africa**  
**www.sasaweb.com**  
**VAT Registration Number: 4680223379**

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## Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
<th>Proportion of events</th>
<th>Anaesthetist average cost per event</th>
<th>Increase in cost per event</th>
<th>Annualised CPE Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA3004</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>90%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3054</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>87%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>3%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3077</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>97%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>3%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3116</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>95%</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>5%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
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<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3237</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>94%</td>
<td>88%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>4%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3361</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>95%</td>
<td>82%</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>5%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3353</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>87%</td>
<td>93%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>3%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
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<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>RA3580</td>
<td>Without BMI Modifier</td>
<td>100%</td>
<td>97%</td>
<td>88%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>With BMI Modifier</td>
<td>0%</td>
<td>3%</td>
<td>22%</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

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**SAPIENTIA ET ARTE CUSTODIUS**

**President | Prof. B Biccard**  
**Vice President | Dr. L Lasersohn**  
**President (Past) | Dr. DHS van Zijl**  
**Chief Executive Officer | Ms. N Zimmelman**  
**National Secretary | Prof PJHL Fourie**  
**National Treasurer | Dr. S Chetty**
Notable across all procedures over the period 2010 to 2014 is an increase in the reported patient population for a BMI greater than 35. SASA detailed this possibility to the HMI Manager Clint Oellermann on the 27th of February 2018. Important to note are the procedures of 0646 – knee replacement and 1761 – cholecystectomy that are both more likely to be required in obese patients. The BMI code increases the time component units reported by an increase of 50% that should then result in an invoiced amount of 20% higher as a total. That stated, it is evident that in some circumstances (e.g. 1127 tracheotomy) that the increase is much higher than 20% when the BMI code is reported for. This would then be explained by other interventions required in the patient population such as invasive monitoring or post-operative intensive care or high care as examples. The explanation (as shared in the communication of the 27th) is likely a combination of members being aware of reporting for this code and the increasing incidence of obesity in the insured population over time. The direct contribution of this code to cost is estimated to be between 0.5 and 1% and possibly higher with resultant requirements for more invasive intra and post-operative interventions and monitoring. With the time constraint we were unable to extract the exact amount attributed and how much it would then contribute to the "unexplained increase". This, however, explains how controlling for co-morbidities may not necessarily control for the change in cost that morbid obesity affects in the anaesthesia environment.

In order to highlight the further cost implication of co-morbidity as it relates to anaesthesia and cost reporting that may not be controlled for by usual statistical methods, we attempted to interrogate procedures and ICD10 codes as they relate to possible co-morbidities. The data retrieved was of poor quality, reflecting the majority conduct of reporting only the ICD10 code primarily resulting in the need for the procedure and often not reporting for secondary codes such as hypertension, diabetes and other chronic conditions that may result in the reporting of additional codes. This again highlights the possibility that co-morbidities could not easily have been interrogate with the data available to the HMI.
Reporting Granularity

The failure of schemes to report on a granular level as to the anaesthesia services delivered, but only per procedure item, results in a skewed analysis that does not accurately reflect either the time taken or services delivered that is easily identified by codes reported per invoice submitted.
## SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS
Official Group Of SAMA
Association Not For Gain

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category</th>
<th>Proportion of events</th>
<th>Average/median cost per event</th>
<th>Increase in cost per event</th>
<th>Annualised CPE increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>R420004</td>
<td>Without ICU codes</td>
<td>80%</td>
<td>2,840</td>
<td>2,552</td>
<td>2,806</td>
</tr>
<tr>
<td>With ICU codes</td>
<td>16%</td>
<td>2,840</td>
<td>2,552</td>
<td>2,806</td>
<td>3,899</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>2,840</td>
<td>2,552</td>
<td>2,806</td>
<td>3,899</td>
</tr>
</tbody>
</table>

### VAT Registration Number: 4680223379

### With/Without Intensive care codes

- **R420004**: Intensive care: Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-cona, asthma, gastro-intestinal haemorrhage, etc.) / Per day
- **R420005**: Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthama, acute pancreatitis, endoscopy, fluid balance, etc. Patient may or may not be part of the active system support) / Per day
- **R420006**: Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients who require multiorgan systems intervention / Per day (primary practitioners)
- **R420007**: Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients who require multiorgan systems intervention / Per day (per involved practitioner)

### Subsequent days, per day

- **R420004**: Intensive care: Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-cona, asthma, gastro-intestinal haemorrhage, etc.) / Per day
- **R420005**: Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthama, acute pancreatitis, endoscopy, fluid balance, etc. Patient may or may not be part of the active system support) / Per day
- **R420006**: Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients who require multiorgan systems intervention / Per day (primary practitioners)
- **R420007**: Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients who require multiorgan systems intervention / Per day (per involved practitioner)
The above interrogation of the same codes when considered in conjunction with reporting of ICU care undertaken by the anaesthetist in terms of post-operative care, was considered in an effort to expose the assertion, in the short time available to us, that corrective tariff over time - both open and restricted schemes aggregated. Using the same reported codes we see a consistent above CPI reimbursement per annum as an application of corrective tariff over time – this across both the large open and restricted schemes aggregated. Furthermore and in line with expectations, anaesthetists are increasingly required to look after patients requiring intensive care admission post procedure. The procedures interrogated were chosen as there will be an incidence of admission to ICU either because of procedural complexity or likely co-morbidity associated with the condition. It is evident across the schemes interrogated that a corrective tariff above CPI has been applied across the coding structure too contributes to the unexplained increase. It is also important to note evidence in this table of the annualised cost per event (last column) that reflects a clear sign of corrective tariff applied over time above CPI when considering the period 2010 to 2014 for anaesthesia. This contributes further to the unexplained increase as described above and in our submission prior. We did not have the time to quantify the exact contribution of this evidence (ICU component and corrective tariff).

Coding Generally and New Codes
The introduction and variable recognition and remuneration by Medical Schemes of new codes for anaesthesia. These code introductions brought code unit recognition in line with internationally accepted norms and did not reflect an increase outside of such accepted norms. These codes are still variably funded and accepted by different schemes. The introduction of the new codes in late 2011 and acceptance of these by some schemes in 2012 certainly explain the notable “spike” observed in 2012.

At this point we would like to comment on the HMI notes regarding societies and coding specifically as these may be assumed to relate to SASA, as well as other organisations.
**Point 159:** Specialist associations usually represent the interests of their members in relation to negotiations with funders on billing, coding, and tariff determination. They also provide industry research and analysis, and some provide administration or management support to members, including billing and practice management.

SASA again states that we do not negotiate with funders with respect to billing or tariff determination. We do discuss coding as it relates to anaesthesia. We do not provide administration and management support to our members and do not participate in billing and practice management. We do publish guidelines for private practice which underscores ethical practice related to billing and coding for services delivered. We would like to comment on the following statements from the report and provide evidence that in fact disputes these statements with respect to SASA, its coding guidelines and its member conduct:

**Point 162.** The Commission (and subsequently the HMI) has received a range of complaints in relation to the conduct of practitioners, particularly specialists, through associations with regard to the tariff setting, billing practices, and coding practices. The primary complaint is that the specialist associations are a platform for collusion.

**Point 167.** Importantly, it seems that funders were not able to resist these changes, a situation that is indicative of unequal bargaining power between funders and practitioners in these cases.

**Point 168.** The inquiry considered the current practices and concerns related to practitioner groupings and determined that these mostly relate to horizontal coordination or collusion between practitioners in relation to the tariff and fee determination, coding and billing practices, and network negotiation.

**Point 182.2.** When a practitioner grouping directly or indirectly negotiates tariffs or when it issues coding guidelines, for example, and the members of the association align themselves with the decision of the association and adhere to it, this constitutes at minimum a concerted practice and at worst an outright agreement between the members.
**Point 182.3.** The tariff schedules set out prices for various procedures or services. Medical codes can be readily converted into prices. Billing practices, which are sometimes managed via associations, can be classified as trading conditions in terms of section 4 of the Competition Act.

**Point 183.** The inquiry is thus of the view that the determination of tariffs, fees and standardisation of certain business practices (such as coding) via associations are likely contraventions of section 4(1)(b).

The purpose of the SASA Coding Guidelines are many fold.

1. This guideline is an educational tool to enable new entrants into the private sector to participate competitively in the sector. Without this knowledge entry into the sector is more difficult, with reliance on billing companies or management companies to comply with relevant legislation by the practitioner and, owing to the acknowledged lack of post graduate teaching in this respect, this enables practitioners to comply with relevant legislation and scheme requirements.

2. The guideline is compiled with reference to relevant legislation and the SAMA Doctors Coding Manual as published annually. The benefit to schemes and the public is that they have an ethical and published manual that is clear and references anaesthesia and code reporting thereto exclusively. The manual has benefited schemes and scheme members who have either audited or laid complaints against SASA (and non SASA) members, as there is a clear reference to what is expected, reasonable and legislated in the sector. SASA is happy to provide examples of collaboration with schemes and scheme member communications that have resulted in recovery of funds by schemes and changing of errant coding practice by practitioners.

3. The guideline provides clarity that is not provided through the last published and gazette coding from the NDoH, which lack of clarity results in coding practice that results in increased costs that may or may not be recovered by schemes. In point 107 of the HMI recommendations on collective bargaining, the Inquiry acknowledges receipt of a
number of submissions suggesting that that “competition authorities’ decision to prohibit collective bargaining is responsible for a tariff vacuum.” Whether this tariff vacuum is perceived or real, there is no reasonable alternative that has been proposed, even in the recommendations, to a robust and well functional coding system. Since 2006, outside of the SAMA published coding manual, there has effectively been no accountable or responsible government department or regulator that has since published a guideline to coding (and important to note without the intention or otherwise of influencing tariff). Practitioners would find it far easier administratively to simply issue a single line item invoice for “services rendered”. SASA has, therefore, stepped up to publish a guideline that adds ethical value and guidance to the entire system and does not assign any competitive advantage in the system it informs. The guideline references relative value units but not rand conversion factor. The guideline provides clarity on this point.

With the above stated, the following is pertinent with respect to SASA and the statements extracted from the report:

- Outside of these guidelines and the design and establishment of an ethical ARM structure, SASA has never participated in any of the events listed in Point 168. With respect to coding, and bearing in mind the comments of the HMI referred to earlier that coding systems are “integral to adoption of provider payment systems and essential to a well-functioning healthcare system – essentially a public good”, SASA’s intention and the resultant effect of the coding manual compiled has not been anticompetitive or collusive in nature. It has served for good for the public in terms of a clear reference (lacking in other disciplines) as well as for collaborative exposure and control of wasteful/ fraudulent expenditure. This can be supported by those administrators that refer to our coding manual in such instances and evidence provided in support of this.

- To further quote the Inquiry report: “…forms of coordination between competitors in the same market may be beneficial to competition (e.g. information sharing on patients’ conditions, medical coding, and standardisation of quality standards)”. It is therefore important to assess each society and conduct on their own merits.
- The introduction of a change to some codes in 2011 (see impact below) that align with international norms of CPT, were adopted through a robust process and are included in our coding manual, does not simply translate into “setting a fee”. There is variable uptake of these codes in terms of funding by schemes, dependent on their choice to recognize these codes or not. Furthermore the scheme unilaterally decides their rand conversion factor (RCF) to apply to the RVUs and as such are in a position to manipulate the RCF to achieve a cost neutral effect, or not recognize the codes at all.

- Evidence is provided hereunder that, as stated in Point 164. by Discovery Health, that “In practice...each year, every scheme unilaterally revises the tariffs it is willing to pay to health professionals for each billing code” and that despite the coding manual stating that codes may be reported, they are not when a scheme does not recognise the code. This is a clear indication that Out Of Pocket (OOP) payments for patients are considered by practitioners and that the schemes/administrators have ultimate control in this domain.

The following codes were interrogated as introduced in 2011 for schemes where data was accessed as above from 2011 to 2014:

0032 - Any procedure performed in any position other than lithotomy or supine has a basic minimum value of 5.00. When the basic anaesthetic units for the procedure is 3,00, two extra anaesthetic units should be added. If the basic anaesthetic units for the procedure is 4,00, one extra anaesthetic unit

0034 - Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 5,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, two extra anaesthetic units should be added. If the basic anaesthetic

0043 - Patients under one year of age or over 70 years of age: For all cases where the patient is under one year of age or over 70 years of age 3,00 anaesthetic units to be added

5431 - Physical status modifier: Normal health patient, ASA 1: Add 0.00 anaesthetic units

5432 - Physical status modifier: A patient with mild systemic disease, ASA 2: Add 0,00 anaesthetic units

5433 - Physical status modifier: A patient with severe systemic disease, ASA 3: Add 1,00 anaesthetic unit
5434 - Physical status modifier: A patient with severe systemic disease that is a constant threat to life, ASA 4: Add 2,00 anaesthetic units
5435 - Physical status modifier: A moribund patient who is not expected to survive without the operation, ASA 5: Add 3,00 anaesthetic units
5436 - Physical status modifier: A declared brain-dead patient whose organs are being removed for donor purposes, ASA 6: Add 0,00 anaesthetic units

The introduction and effect of these codes, we asserted, was realized over time as the schemes decided to fund the codes. For the schemes considered here, there was a decision to fund the codes by one scheme representing a large portion of the schemes administered and slowly other schemes have either decided to fund or not fund the code.

The resultant reporting for the codes by anaesthetists for the funded codes appear as follows:

Table showing trends in billing utilisation over time (both IH and OH)

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>0032</td>
<td>0.348%</td>
<td>1.579%</td>
<td>2.717%</td>
<td>3.453%</td>
</tr>
<tr>
<td>0034</td>
<td>1.207%</td>
<td>6.117%</td>
<td>6.847%</td>
<td>7.008%</td>
</tr>
<tr>
<td>0043</td>
<td>1.117%</td>
<td>5.773%</td>
<td>7.200%</td>
<td>8.114%</td>
</tr>
<tr>
<td>5433</td>
<td>0.001%</td>
<td>0.005%</td>
<td>0.004%</td>
<td>0.004%</td>
</tr>
<tr>
<td>5434</td>
<td>0.000%</td>
<td>0.001%</td>
<td>0.001%</td>
<td>0.002%</td>
</tr>
</tbody>
</table>

It is evident that these codes, as stated, have a reported variable uptake in terms of reporting over time (0032, 0034, and 0043).

It is important to note and in direct contrast with the assertion of “unequal bargaining power” on the side of practitioners, or the ability to force funding by practitioners on schemes (small or large), when codes are not funded (5433 and 5434) the codes are, for all intents and purposes, not reported for. This is a clear sign that the power to influence code reporting does
not reside in the manual published but rather the decision of a fund to fund codes that may be introduced. We are able to replicate this example with codes 0034 and 0043 that may have not been accepted by other schemes for funding. It is important to note that many practitioners write off amounts not funded in terms of new codes as an agreement between them and each individual patient at the time of consenting the patient. We, therefore, contend that coding guidelines when compiled with the intentions SASA has in mind, in no way contravenes 4(1)(b) and, on the contrary, provides schemes and patients ability to interrogate coding, decreases information asymmetry, allows for robust and fair peer review of code reporting (and not RCF or tariff applied as this is not permitted in law) and is essentially “a public good”.

Impact of new Codes

In order to quantify our assertion of the quantum likely contributed to the “unexplained increase above CPI, we interrogated the 3 codes - 0034, 0043 and 0032 with the following results:

Table showing amount paid to Anaesthetist for procedure as a proportion of total amount paid to Anaesthetist (both IH and OH)

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>0032</td>
<td>0.033%</td>
<td>0.137%</td>
<td>0.207%</td>
<td>0.249%</td>
</tr>
<tr>
<td>0034</td>
<td>0.083%</td>
<td>0.372%</td>
<td>0.390%</td>
<td>0.385%</td>
</tr>
<tr>
<td>0043</td>
<td>0.184%</td>
<td>0.905%</td>
<td>1.093%</td>
<td>1.217%</td>
</tr>
</tbody>
</table>

The sum of these 3 codes funded across the schemes included in the analysis amounts to 1.851% of the total anaesthetic fees paid to anaesthetists for 2014 and would not be otherwise have controlled for in the CPI calculations applied by the HMI.

New Technology

The impact of new technology in anaesthetic practice as well as the impact of guidelines that provide membership with ethical rules around code reporting must be taken into account. One
example (as elucidated in the submission) would be the introduction of ultrasound as a standard of practice where anaesthetists are required to develop skills to apply ultrasound in the placement of invasive lines and nerve blocks. This requirement being a standard, and a medico-legal requirement too, results in an increase cost of care (time taken to perform the ultrasound, equipment costs not always provided by facilities and professional costs that would otherwise be incurred by a radiologist for example).

We interrogated code reporting for ultrasound code 5103, together with the placement of plexus blocks as well as invasive monitoring lines, as expected by the introduction of new standards of best practice. It is important to appreciate that the adoption of this modality requires additional skills and training and takes time to adopt in any system and is less likely to be adopted by some practitioners.

<table>
<thead>
<tr>
<th>CODES</th>
<th>1218</th>
<th>1215</th>
<th>2802</th>
<th>2800</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>25%</td>
<td>42%</td>
<td>41%</td>
<td>41%</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
<td>31%</td>
<td>27%</td>
<td>30%</td>
<td>25%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11%</td>
<td>9%</td>
<td>6%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14%</td>
<td>12%</td>
<td>7%</td>
<td>11%</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Billed: 5103 - Ultrasound soft tissue, any region

Additional codes:
- 1215 - Insertion of arterial pressure cannula
- 2802 - Procedures for pain relief: Peripheral nerve block
- 2800 - Procedures for pain relief: Plexus nerve block
- 1218 - Insertion of central venous line via subclavian or jugular veins
It is noteworthy that there is a significant increase in reporting code 5103 associated with code 2800 (plexus block) and an insignificant change with respect to other codes, although there remains a cost associated with reporting code 5103, in addition to the other codes reported. The relative value of the total anaesthetic cost over the considered period is reflected hereunder:

Table showing amount paid to Anaesthetist for procedure 5103 as a proportion of total amount paid to Anaesthetist (both IH and OH)

<table>
<thead>
<tr>
<th>Code</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>5103</td>
<td>0.005%</td>
<td>0.044%</td>
<td>0.180%</td>
<td>0.328%</td>
<td>0.431%</td>
</tr>
</tbody>
</table>

The relative value of code 5103 and the introduction of this technology and standard of practice has effectively added 0.426% to the anaesthetic cost over the period 2010 to 2014 and would contribute then to the unexplained increase above CPI.

**Differential between Open and Restricted Schemes**

**Point 196:** Further, the HMI found that the increase in unexplained portion in costs per admission is higher when anaesthetists are paid by closed/restricted schemes than when they are paid by open schemes.99 As indicated in that report the HMI found that “cost per admission increases as well as the unexplained increases are significantly larger for restricted medical schemes than open schemes. Since previous analyses have not suggested a material risk profile difference between the two groups, this may suggest a price effect since restricted schemes are generally smaller and may be less able to secure favourable tariff agreements (or agreements at all) with specialist groups.” (previously point 167 in the HMI practitioners report)

This point was specifically addressed in our submission of 19th February 2018. We acknowledge the HMI has “suggested” why this effect is noticed but again ignored our submission. Our alternative explanation as pasted from our submission below bears reference:
“We submit that the differentials identified between open and restricted schemes cannot simply be assumed to have been caused by tariff increases incurred due to lower bargaining power. It has been the smaller schemes that have been less willing and/or less able to implement the recognised and needed re-alignment of anaesthesiology rates. Discovery Health, for example, implemented half of the proposed increase (i.e. a 20% increase) in the year following the CMS ruling. Further, closed schemes sometimes have a higher percentage of their patients on higher plan types that reimburse more, resulting in them paying more and some members billing at that tariff - CAMAF may be an example.

In the current healthcare environment, any scheme, big or small, has the same negotiating power with any practitioner discipline. As the practitioners may not collectively bargain (and assessment of impact of professional association on practitioner rates has indicated that there has NOT been collective bargaining or collusive practice), it is simply a decision by each individual practitioner whether they accept a scheme rate or charge a co-payment. Again, the aggregation of rates around scheme rates indicates that this assumption holds true.

The Report conclusion that, given all other variables being essentially the same, that the differential between open and restricted schemes is likely the result of bargaining power differentials with respect to the practitioner is simply unsupported by the evidence. Specifically, the report states that it is an unexplained “tariff” difference. SASA contends that is an unexplained (albeit explainable) “scheme benefit” difference.”

SASA is disappointed at the failure of the HMI to either report on our submission, explanation or even acknowledge an alternative view and again opt to suggest anti-competitive or nefarious activity by SASA or its members.
SASA Membership

**Point 197:** Analyses were performed to compare SASA members with non SASA members and are reported in Tables 72-74 in the Expenditure analysis report 5: Practitioner analyses. In that analysis we found that SASA anaesthetists are between 5% and 8% cheaper than their non-affiliated peers.

SASA raised concerns about these results and requested a meeting with the inquiry with regard to two issues. The HMI noted their concerns and agreed to publish a comment on these tables.

**Point 197.1:** SASA’s first concern is that the inquiry’s analysis indicated that most anaesthetists were not members of their society, which they dispute. From SASA’s data they estimate that the majority of anaesthetists are members of the association.

**Point 197.2:** The list of members used to compile Table 72 was provided to the inquiry by SASA but it appears that our classification is incorrect. The reason for this is that a doctor can have two numbers that identify him or her; an individual number and, if they are part of a group (as many anaesthetists are), they can also have a group number. In submitting a bill, both numbers are usually included. However, when schemes process the claim, one or the other may be used and there is no consistency in the usage. SASA provided us with the individual practice numbers and we may have had the group number from many of the schemes. There was thus no way for the inquiry to allocate the numbers provided to us by the schemes. We agreed with SASA that we would state this in public and ignore those results. It does, however, point to the need for a standard numbering system so that there is a consistent way of identifying any provider.

With respect to 197, we acknowledge the agreement by those HMI representatives present that understanding was reached by those present as to why the reported numbers were incorrect.
We further discussed at this meeting:

- Group practices and how schemes analyse billing,
- How SASA data would not reflect BHF numbers provided by schemes for adequate cross walk,
- The lack of reporting by schemes for practitioners delivering services (MP number, individual practice number and group practice number),
- Billing that may occur by a practice number that does not always incorporate the individual that delivered the service (can occur with paid locums or agreements between practices like O&G).
- How practice numbers and billing trends skew data (large group practices that practice full time and have this as only income source have the same weighting for average billing compared to limited private practice with 12 anaesthetics delivered per annum)

This was further explained in our written submission. It is an important note that the appointed actuaries WTW do conduct work for medical schemes and should have been in a position to ensure this report was more accurate and such an oversight did not occur.

SASA is most concerned with the HMI’s final analysis of member data and SASA’s reaction thereto.

**Point 198**: A second issue raised by SASA was that it appeared from the inquiry’s expenditure analysis that non-SASA members received better remuneration than members and that this was disadvantageous to SASA in recruiting new members.

SASA takes specific exception with this statement and interpretation of our submission and intention. We would formally like to request, outside of our written submission, where or what the author of this point has referenced to reach this conclusion.

With respect to our written submission regarding member numbers:
SASA noted the percentage claims attributed to members vs non-members in the Report. Given our membership numbers against the registered practitioners within the country, this did not seem to be a true reflection of the membership ratios. A simple reverse calculation where it is stated that only roughly one third of claims were submitted by SASA members, taking into account that SASA members (specialists) in either full time or limited private practice total 1 103 members, it would imply that the total number of specialist anaesthetists in private practice exceed 3000, which is not the case.

Clearly the HMI appointed actuaries failed in due diligence to do a simple cross reference to ensure the data it was reporting was correct. We accepted this as a workload issue and not intentional. We went on in our submission to state that:
“The above data is based on 2016 SASA membership data, as this was the data submitted to the HMI at that time. SASA has, subsequently, increased its membership numbers and these numbers are likely to be under-represented.”

Furthermore, later in our submission we state:
“Growth in the impact of SASA
SASA is a relatively strong professional association, whose work and influence has been growing over time. SASA is a strong advocate of cost-effective and cost-conscious healthcare provision, as can be seen in our positions on and peer review supported low-flow anaesthesia and appropriate use of the new, but relatively expensive, drug Bridion. That notwithstanding, SASA also advocates the appropriate coding by our members, so as to ensure that they are properly reimbursed for the services they do provide.”

At no time, either in oral or written submissions or interactions, did SASA or any of its representatives either imply or state that non-members receiving “better remuneration than members …. was disadvantageous to SASA in recruiting new members.” As stated above and in our submission, SASA remains a strong advocate of cost-effective and cost-conscious healthcare. We re-iterate these to members in many formats. This is not a statement made in
response to the HMI’s assertion but stated as far back as 2009 in the attached position statement regarding the responsible use of healthcare resources to our members. We have continuously engaged in both the private and public sector in an effort to drive quality, contain costs and maintain access to quality healthcare.

While the HMI asserts that our “issue” pertains to our belief that a perception among members is that they should earn more than non-members, we would far rather be in a position to assert that our members uniformly bill less than non-members. We specifically assert and believe that the differential identified by the HMI should hold true, given the efforts of the SASA in this regard. It is hard, however, to make any conclusions in the regard, based, as it is, so comprehensively on flawed data.

Furthermore, our membership base and profession are well educated and informed through our member communications that SASA has not, and could not, be in any position to negotiate or dictate tariffs to funders or administrators. While we do promote our active engagement in all sectors, including government and regulators, and admittedly where such legal engagement has been listed on our website, it is the active participation and engagement on every level in the public and private sector that translates into a successful and sustainable healthcare sector. This is far more important than the promise of a few percent increase in tariff to garner member support.

Moreover, as SASA is unable to determine or advise membership on tariff, even in the event that SASA believed it could attract membership by promoting better tariffs for members, it would never be able to be substantiated. The tariffs paid for anaesthesia services apply to all anaesthetists irrespective of whether anaesthetists are members or not. While SASA may be in a position to hold its voluntary membership to account for ethical or clinical practice, SASA has no ability to influence funding to its members by funders or to assert that services provided by members are in any way different to non-members.
We therefore directly challenge this assumption and conclusion by the HMI and ask for evidence by the HMI that supports this assertion.

Statements about SASA

Point 199: The second concern raised by SASA is particularly interesting. Fundamentally, SASA was concerned that its image as an association would be tarnished if it appeared (incorrectly) that its members were not getting the highest fees. However, SASA claims on its website that one of the benefits of joining the association is that it will negotiate fees for members. This illustrates that associations do not see their collective price setting and coordinated action as anticompetitive.

Point 200: The inquiry believes that SASA practice implies that a restriction of competition exists, and that their practices should be referred to the Competition Commission for further evaluation.

The “particularly interesting” note in Point 199 again makes an arbitrary assumption with no reference and, we contend, is simply not factual. At best, the assumptions and conclusions reached by the HMI, and as stated in the submission of the 19th of February: “was published without any attempt at engagement with the profession and in a manner prejudicial to the profession” and now repeats the same prejudicial statement.

The details and explanation of the website statement has been included in this submission. Interrogation of either our membership or stakeholders would make clear that SASA is both acutely aware of competition legislation and has never engaged in “collective price setting and coordinated action” to determine tariff. Further evidence of SASA acute awareness of competition legislation and effect is SASA design and conduct of the SASA Event Based Contract (EBC) where SASA has refused on all occasions over the past 4 years (this can be verified by a number of facility and administrator stakeholders) to entertain any discussions on tariff and referred these discussions to be had with practitioners. In the Discovery Health adoption of the SASA designed contract, the administrator has offered tariffs directly to practitioners without SASA involvement.
In the SASA conclusion of our written submission:

“The impact of a Report that leaves explainable analysis unexplained without any engagement with the affected discipline, and that misstates membership data is, unfortunately, quite significant. Not only does this impugn the reputation and status of the professional society, but creates unnecessary and undeserved tension between colleagues in the perioperative team.”

The HMI has chosen to interpret this (for reasons unknown) as directly referencing membership numbers and the fees our members received. This despite the conclusion referencing a multitude of incorrect assumptions and calculations in the practitioners report. To arrive at a conclusion that our “fundamental concern” regarding our “image” was related to tariff is patently false. What does impugn the reputation of the society are allegations of impropriety, unlawful conduct and no attempt to consider our previous submission on the causes of “unexplained” tariff increases (with the negative connotation of anything “unexplained” or covert). That the HMI chooses to concentrate on its own incorrect reporting of tariff discrepancy between members and non-members, when our face to face meeting and written submission did not in any way state anything close to this, is worrisome. Our fundamental concern remains that those entrusted to “find the truth” have failed to take our submission into account and effectively ignored it in establishing the Provisional Final Report.

While SASA will comply with any competition commission evaluation, the statement that SASA’s statements and conduct represent either our inability to recognise collective price setting or coordinated action as anti-competitive is false.

It is also noted that those organisations, often only with volunteer capacity, that have worked hardest to engage with the Panel have also faced the harshest criticisms. As stated in every submission in some or other manner, the SASA reaffirms our commitment to this critical process. We do believe there are matters that can and must be enhanced in terms of cost-effective healthcare delivery. We wish to remain what we believe has been a constructive and engaged partner.
Section 3 - Main report Additional Comments

Executive Summary

- Stewardship - In the opening statements of the Executive Summary, the Panel notes the lack of effective stewardship and significant regulatory failures in the healthcare market. We note, recognise and support the mechanisms proposed to enhance the accountability of practitioners. What is, however, lacking is a greater level of accountability from the government and the regulatory authorities. Many of the recommendations rely on a greater level of implementation and effectiveness from entities who have already failed in their responsibilities or use the same mechanisms to create entities that have resulted in the regulatory vacuum that currently exists. For example, the current legislation requires the review of PMBs every two years. The report recommends the evaluation of these every three years, but through the same entity that has not implemented the legislated review in nearly 20 years. Further, the report recommends a much more effective licensing process by the Provincial Departments of Health, while still recognizing that the existing framework has not even been properly implemented. SASA does believe that the coordinating and oversight role proposed by the SSRH may achieve the required accountability here, but, again, urge an alternate mechanism for the establishment thereof and, further, recommend that this entity be required to report, on a regular basis, directly to Parliament. The Inquiry further highlights the difficulty assessing and measuring quality – a further failure of regulators and government to carry out its mandate in this respect. This is concerning and should be well planned for in terms of the recommendations. Further, the report recommends a much more effective licensing process by the Provincial Departments of Health, while still recognizing that the existing framework has not even been properly implemented. SASA does believe that the coordinating and oversight role proposed by the SSRH may achieve the required accountability here, but, again, urge an alternate mechanism for the establishment thereof and, further, recommend that this entity be required to report, on a regular basis, directly to Parliament.
• Much of the evolution of the private market has resulted from the direct absence of regulatory policing. Frameworks and laws exist to cater for much of the failures in the sector, but not in the absence of regulatory oversight and implementation of legislation.

• We note the general aversion to Fee for Service models and agree the model is open to over-servicing and inefficiencies funded by the payer. That notwithstanding, we do not support the theory that the sector is entirely dysfunctional and massively over-priced. When compared on a dollar for dollar basis with other OECD countries with similar levels of service to the private sector, the costs of the South African service is many multiples lower. That stated, it does not achieve the aims of accessibility and quality delivery to the entire population.

• While not necessarily organized activities in the private sector, many disciplines (Anaesthesia being one) have organized professional development activities throughout the year, peer review mechanisms in place for all aspects of the sector in which it operates and morbidity and mortality meetings organized by members. They are not absent throughout the private sector. SASA members by their voluntary association are subject to voluntary peer review as members of the society. In vast majority, members welcome this where complaints or queries are instituted through the society. We have highlighted earlier in this submission that SASA and its volunteer members provide regularly updated and evidence based revised practice guidelines are made available to members, other stakeholders and the public.

• The notes regarding ICU in **Point 19** are supported entirely by SASA. The failure of regulatory oversight has permitted standards and nursing ratios provided in the sector to drop in general wards necessitating level of care escalation that would ordinarily not be the case in a well-regulated and accountable environment. This is partly due to a lack of nursing expertise to deliver care in the sector as would be expected. SASA continues to work with stakeholders to find ways to remedy the failure of these standards in the
absence of this regulatory policing, partly through enhancing accountability of all role players in the SASA designed Event Based Contract.

- We do not agree with the Inquiry assumption (Point 21) that SID is evidence that there is time for specialists to over-service. Medico-legal implications and time pressures make it far quicker and secure to investigate patients with more expensive modalities, for example, than repeated follow-ups and consultations. When looking at OECD countries with high medico-legal exposure it is clear that costs are driven up owing to this phenomenon and not for some nefarious purpose or inefficient specialists. The efficiencies and amount of service provided in the private sector far exceeds that of the public sector in the majority of respects.

- We disagree with the assertion that schemes have not proactively managed PMB payment problems. Schemes have reacted in two distinct ways to manage same –
  - By establishing networks that render the PMB exposure manageable, and
  - Although illegal and not in the spirit of the intention of Regulation 8, simply do not pay for PMB conditions and treatment citing that they have networks (when they don’t) or simply not processing payment on these claims. As the majority of practitioners do not have the time to address same on behalf of patients and complaints to the CMS take years to resolve, schemes effectively manage their exposure with no hindrance.

- We note the heading “Funder Profitability” should likely be amended to “Administrator profitability” as funders by definition are not for profit entities.

- Information Asymmetry - we note the opinions of the Inquiry with respect to this and expensive technologies. The private healthcare sector provides, in majority, a first world service to medical scheme members, albeit in a poorly regulated environment with no effective measurements in place. The assertion that there is unfettered use of technologies
and costs that are not monitored and challenged is not fact. The funding of new technologies is often delayed by funders who will fail to fund these until evidence of benefit is provided. The funding of Sugammadex, a novel and necessary new drug, took in excess of 1 year to fund in the majority of the sector despite clear evidence that it has important clinical application and is in some instances a life-saving medication. This was only because of the funding implications. The collaboration between SASA and the market has enabled this funding, and peer review when required in terms of inappropriate use.

- We are supportive in totality with the statement in Point 61 of the summary in terms of the aim of the Inquiry with respect to recommendations. Our concern with respect to ineffective regulators cannot be over-emphasized with new proposed regulators encouraged to be formed by the recommendations that should be apolitical and constituted with the necessary expertise and resources to fulfil their mandates.

- We note your definition of the purpose of specialist organisations being: “to ensure that specialists are well remunerated in addition to other activities”. The SASA Mission Statement is to lead the science and practice of anaesthesia in the interests of patient care. Our core purposes include clinical education, research support and best practice guidelines. Ensuring the sustainability of the profession is important, but is also not purely about “ensuring that specialists are well remunerated”. We argue that this is a very unbalanced and potentially purposefully unrepresentative description of specialist organisations. We request, therefore, that a more balanced descriptor (even that of SA Heart used as an example in a footnote in Chapter 7, although also summarized entirely differently by the Panel) be used.
Chapter 1 – the legal framework for the HMI.

- We specifically highlight and perhaps in support of our prior submissions and the current submission with respect to unexplained increases, that (Point 6) a “factual basis” for the recommendations that support the achievement of access to quality healthcare. We implore the Inquiry to objectively consider and assess our submissions (current and prior) and we continue to make ourselves available should to the Inquiry should it be deemed required.

- Furthermore, while not convenient, it is important to understand that striving for access to healthcare comparable to OECD countries mentioned in this report will take significant financial investment and dedication. This is true in many sectors including accounting, engineering, consumer sectors like motor vehicles and housing, – which too are out of reach of the majority of South Africans. We do, however, have a responsibility and imperative to find ways to circumvent the many external factors that too result in a costly reality in healthcare. Access to poor quality care for everyone is not and should not be the objective.

- With respect to our submissions we contend (Point 28) that in some respects “access to the correct data” has not been enjoyed by the Inquiry and misleading or incorrect conclusions have been arrived at. We continue to strive to enable the Inquiry to find the truth within data and expertise available in the industry. “The integrity of data is crucial to the accuracy of any analysis (Point 36)”. Furthermore we note (Point 42) that this final report has not taken our comments and submissions into account with respect to conclusions reached – not due to “fundamental difference of opinion” as these differences have not been engaged upon with SASA nor has the Inquiry indicated why their conclusions or continued opinion have merit based on data, supporting evidence or fact.
Chapter 2 – the Regulatory Framework

- We specifically would like to note that while competition is important to a healthy market, a more concerning issue is the “for profit” business agenda which is concentrated on primarily and only secondary concern for patient care. A competitive market in healthcare must be counterbalanced by real and effective regulation and oversight/policing or patients will be harmed in the name of “innovation” or “competition” as a covert profit motive. Competition should drive down cost and not quality and always be with patient best interests at its core. The recommendations of the Inquiry, if implemented effectively, would achieve this.

- With respect to comments on employment - the same stakeholders who make the point (Point 2) that there is no policing of policy/regulation now believe they will act in a manner best for the patient and not driving for-profit agenda. There is ample evidence in international literature to confirm that employment of professionals in fact increases operating costs and that those entities who embark on aggressive employment strategies do so, not to improve quality of care, but to secure competitive advantage in the marketplace. The interactions and evolution of the global fee market highlights severe failings and immaturity in the marketplace that need to be monitored and regulated with careful attention to ethical patient centred care.

- We agree with Point 26 with the proviso that quality of care is maintained to a high standard in the face of such competition and that patients and their care are placed before profits. This can only be achieved with fastidious regulatory oversight and outcomes measurement in place with social and financial incentives (positive and negative) in place for participants to ensure they deliver best care.
The statement in **Point 51.2** regarding PMBs and the imposition of a co-payment or deductible by schemes is counter to the intention of PMBs in Regulation 8. No scheme should be empowered to impose a deductible that results in patients being reimbursed less than their paid for plan cover just because they have a PMB condition and have used a non-DSP. Most schemes and the public would not consider this ethically reasonable.

### Chapter 3 – Health Sector Overview

- The calculation by the Inquiry of out of pocket (OOP) payments is understood to be that any shortfall between what is billed and what the scheme reimbursed would then have to be covered by an OOP payment. This is not the general practice in the sector with large numbers of practitioners discounting their fee to what is reimbursed. The fact that practitioners charge a uniform unique tariff in line with their billing policy is in line with HPCSA rules, the CPA and the Competitions Act. The estimate in 4.5 has been noted to possibly be an underestimate – we point out that it may too be an over estimate.

- We note that while an assumption was made in **Point 60** regarding market function post the competition commission ruling of 2003, this report highlights the failing of this assumption and the practical impossibility of “each scheme negotiating a price schedule with each provider.”

- **Point 63** describes the NHRPL evolution and HPCSA published rates and highlights the lack of analytical work or social consultation by the HPCSA. It is important to be fair that the NHRPL suffered from the same deficiencies and this was highlighted in the 2010 Ebersohn ruling (**Point 68**).
• Pay for performance (Point 98) - ethically this concept in the delivery of healthcare, while promoted in business, is contentious, in our opinion. Practitioners should always be doing their best and meeting standards. Where they are not met, practitioners should be policed, mentored and levels improved or be removed from delivering the service. This is not a factory output measure. To imply that delivering less than good is acceptable (by paying more to those who meet standards and still retaining services from those who deliver less) is a problem in healthcare terms. There are various measures, each with limitations and potential for discrimination to providers and patients. This may have unintended consequences. We propose that management and alignment of moral, social and financial incentives can be carefully constructed to achieve superior service and outcomes with accountability and responsibility in an ethical framework.

• On page 53, Point 112, the Panel defines SASA as a provider-initiated network (such as an IPAF), based on our submissions. As SASA itself had no contractual arrangements or network agreements of any form in place at the time of this report, SASA does not understand how it meets the definition of a provider-initiated network. Furthermore even our agreement with administrators contains no influence or attachment to financial value for participating clinicians or network on anything other than a cost neutral basis for the society and no interference or even sight of the values agreed to between funders and clinicians. Furthermore the coding guidelines (which we have comprehensively explained and discussed earlier) we provide membership are part of a comprehensive set of guidelines and support SASA delivers. Evidence based practice guidelines, wellness support, peer review, educational and CPD activities, patient and funder interaction portals and more are simply omitted and certainly not provided by the other defined provider initiated networks. We request that the Inquiry provides clarity as to these differences as SASA is certainly not in the domain of a provider initiated network.
• We are unsure as to how the Inquiry reaches the conclusion in Point 147 that expenditure increases do not seem to be due to aging population/disease burden. We agree that this is not the only cause but it must contribute in a disease burdened and aging society.

Chapter 4 – Competitive Assessment Framework

• SASA has previously commented and indicated its strong support for the mechanisms recommended to address information asymmetry. We agree it exists and that it is not in the interests of the patient for this to persist. SASA also notes, however, that the current market is characterized by information asymmetry in favour of the funders, in many instances, and this is also often to the detriment of both patients and practitioners. We are experiencing a change in the wish to collaborate and share data for the sake of outcomes measurement and patient centred care over the past few years.

• We specifically highlight Point 76 of the report in relation to “unexplained increases above CPI” explained earlier in our submission and request the Inquiry to consider same – “The HMI acknowledges that price comparisons in health care, both at a national and international level, are difficult to perform and interpret given the diversity of the products and services involved, the complexities of correcting for the influence of different methods of cost allocation over these products, and; for international comparisons, the influence of purchasing power comparators and the differences in legal, societal and fiscal settings”

Chapter 5 – Funders

• SASA notes the comments in the Chapter about the funder inability or unwillingness to negotiate effective volume-based contracts. SASA reiterates that purely volume-based contracts have proven to be unattractive to anaesthetists, suggesting a resource constraint in this area. SASA has not advocated against network contracts, and does not, in fact, have the market power to prevent the take up of such contracts. Both points are evidenced by
the very strong support for two specific Designated Service Provider Networks (Fedhealth and Discovery Classic) of anaesthetists. We reiterate our willingness, without engaging in any tariff discussions, to work with any scheme or administrator who is genuinely trying to establish effective networks.

Chapter 6 – Facilities

- SASA notes and supports the conclusion that private hospital bed capacity can be used by the state through strategic purchasing to enhance healthcare access. It must be noted, however, that bed availability does not always correlate with provider availability. To highlight this we need only assess the public sector bed availability. The lowest provinces ratio of beds per 1000 population is Gauteng (1.4) and the Western Cape (1.5) with the highest being the Eastern Cape (4.7), KZN (4) and Limpopo (3.5). Various sources including some in the possession of the Inquiry detail the lack of human resources and poor health outcomes in the same regions that have the most bed ratios with respect to population. Furthermore, the distribution of human resources in areas may not be uniform - for example, both the North-West and Free State have a relatively high level of private beds (to patient population), but there are very low numbers of anaesthesiologists (relative to patient population) in both of these provinces.

- SASA notes that there is a significant overlap in the basket of pharmaceuticals in the perioperative environment between the public and private sectors. Pricing and availability in one sector definitely impacts on pricing and availability in the other sector. SASA does acknowledge, however, that the basket of anaesthesia drugs is extremely small in the overall hospital pharmaceutical basket in terms of cost.

- SASA supports the HMI Panel’s view that there should be a greater overlap of both products and services between the public and private sectors and we continuously work hard to drive alignment and sharing. There are some specific medico-legal barriers to private practitioner contributions in the public sector, but SASA is engaging government and the
medical malpractice insurers to try and overcome this particular hurdle.

Chapter 7 – Practitioners
Detailed comments on issues within this Chapter relating to anaesthetists and/or SASA have been outlined in Section 2 above.

• SASA reiterates its views on the scarcity of the anaesthesia workforce. We note and acknowledge that every healthcare system uses different workforces in differing ratios. SASA actively supports The National Committee for the Confidential Enquiry into Maternal Death (NCCEMD). There was also a senior anaesthesiologist from one of the top academic departments on the Ministerial Task Team looking at the role of Clinical Associates in maternal care. While SASA is fully supportive (as noted above) to the development of an appropriate (and not just numerous) workforce, we need to acknowledge that the country faces serious constraints in anaesthesia provision. As also noted above, SASA is advocating for a skills development strategy to be a specific responsibility of the Healthcare Capacity Assessment and Planning Unit of the SSRH. We argue that it would be within this Unit that a more detailed debate on the under and/or over-supply of skills would be needed and to which SASA should then provide evidence and support.

• SASA does note the relatively higher number of new skills in the specialist environment, as well as the relatively higher proportion of these being anaesthesiologists. Given the last evaluation of need within the country (the National Department of Health’s Human Resource Development Strategy, published in 2012 and further attached here), the number of available anaesthesiologists were approximately half of the required number of anaesthesiologists by 2020. As the data clearly indicates that the number of anaesthesiologists has not, in fact, been increasing at a rate that would achieve the projected need by 2020, we can argue that the skills scarcity has been growing over the period under review. In other words, an assessment of relative numbers, without an assessment of the
starting numbers and/or need, is not, in itself, conclusive. Again, SASA argues that a more comprehensive and rational review of the skills of the country is needed.

- SASA further proposes that the abovementioned SSRH Unit also be tasked with making more detailed recommendations as to the potential private training of specialists. SASA agrees that there is possible capacity within the private sector to enhance training, particularly in terms of exposure of trainees to procedures not readily undertaken in public facilities and/or not in the same quantity. However, we are extremely wary of the possible impact on this on the already drastically constrained capacity (including training capacity) in the public sectors. In the research conducted by SASA (and previously shared with the Panel), one of the core reasons anaesthesiologists remain in the public sector, despite significant workplace dissatisfaction, is the ability to provide training.

- SASA notes the comments from Prof. Veller and, more recently, by Gavin Steel of the National Department of Health with regards the increased training of medical practitioners. SASA is encouraged by these comments. SASA often engages with the core stakeholders mentioned here, offering, wherever possible, our support and assistance. That said, current plans for enhanced capacity development focus currently at the undergraduate level. There are some initiatives, such as the one driven through the Discovery Foundation, to review and, where possible, support the development of specialists. SASA argues that, despite the efforts at the undergraduate level, the country should not yet be sufficiently reassured that effective skills development is being undertaken.

- SASA notes the maldistribution of skills, both geographically and with regards to sector. While SASA agrees that some of the remedies recommended by the Panel will address, to some extent, the distribution of skills, such as the licensing of facilities, appropriate incentives, levels of skills and in-reach and out-reach training should form part of a broader strategy to address distribution specifically, under the same Unit of the SSRH. There are many valuable lessons to be learnt, for example, from Australia, where maldistribution is
also a significant problem. SASA would argue that there are many ways to address this issue before a legislative alternative is publicly debated resulting in human resource negative sentiment or implemented and that may have unintended consequences.

- Finally, on the provision of skills for the country, SASA would also like to note our significant concern about both the quality and quantity of nurse development in South Africa. SASA has undertaken significant nurse post-qualification support and development and have, unsuccessfully, tried to engage with the South African Nursing Council on pre-qualification training and nurse specialisation. Looking at the data on acuity of care, this is a critical component of development in the healthcare sector affecting the costs of healthcare delivery.

- With regards to the data on the escalating costs, SASA has addressed those specific to anaesthesia in Section 2 of this report. While we do believe explanations are available, but not given, we also reiterate our long-standing support for the recommended remedies of price benchmarking and shifts to more patient-centric value-based models of care.

- SASA notes that we have, as a profession, taken considerable volunteer time and effort to develop, publish and continually update clinical Guidelines.

- SASA notes that there may be two factors driving the use of co-payments. Only one – the potentially “low burden of collecting” from the patient. This opinion is arguable. The second driver can, and is argued to be the real driver in anaesthesia, be the relatively low and unsustainable rates offered by schemes at the bottom end of scheme reimbursement. As the scheme rates for anaesthesia vary over 520% across all plans, it is not possible for the anaesthetists to know and then charge differently for each and every patient. This is also in contradiction to the HPCSA guidance in this respect and the Consumer Protection Act. As such, SASA guidance to our members is to charge a consistent and ethical rate, based on their own unique practice costs (without, we note, providing any recommendation as to
what that rate should be), and to discount, as needed, on a patient by patient basis. Due to the inconsistency of scheme rates and the low and unsustainable rates of some plans, anaesthetists have been forced to evaluate the high cost of claiming from patients (made up of both bad debt and much increased administration and legal costs) against a sustainable rate. It is important to note that taking VAT, income tax and practice costs into account, base “100%” scheme tariffs result in ultimate reimbursement tariffs that are often below the cost of delivering these services. Calculations in this respect can be provided on request by individual practitioners. These calculations are left up to practitioners where a majority find it possible to discount those members on lower plans when affordability concerns exist. This does not mean that the barriers are low, but simply that they are lower than would be the consequence of not charging a co-payment. It must be noted that very few doctors want to focus on the financial elements, having no training on this. They much prefer to focus discussion and engagements with patients at a clinical level and, thus, the proliferation of co-payments is, we argue, a significant indicator as to the unsustainability of the scheme rates.

Chapter 8 – Excessive Utilisation and Supplier Induced Demand
SASA’s comments with regards Supplier Induced Demand relate more to the recommended remedies therefore and are, thus, outlined primarily in Section 1 above.

- SASA does note that one cause of higher demand being seen in areas where there is a greater supply of practitioners may be that patients from outside of the demarcated areas may be travelling to where the supply of such skills are plentiful. SASA does not have access to any data to support or dispute this cause, but simply note that it was not included in the analysis.

Chapter 9 – Outcomes Measurement and Reporting
Again, SASA has provided comments on OMRO in Section 1 above. SASA further specifically notes that the success of any initially volunteer-based reporting and the involvement of clinicians rely heavily on strong, well supported and ethical professional associations such as
SASA. This need is contrary to the desire to see such professional associations having less strength, as proposed in Chapter 7 of the provisional Report.

Conclusion

SASA again thanks the Panel for all of the work done in preparing this provisional report. We reaffirm our commitment to support the processes within and flowing from the recommendations of the HMI.

We do hope that our additional comments and evidence submitted here will be considered in the development of the final version of the report.

Yours sincerely

N Zimmelman

Ms. Natalie Zimmelman
SASA CEO

CC The SASA Council
    The SASA Membership