THE SOUTH AFRICAN MEDICAL ASSOCIATION
SUBMISSION TO:

The Competition Commission Health Market Inquiry (HMI)
In respect of

Final Comments following the HMI seminars held on 9, 10 and 12 April 2019

2 May 2019
Contents

1. Introduction ........................................................................................................................................ 3

2. Local and international medical ethics standards and medical professionalism.. 3
   Declaration of Geneva and International Ethical Codes ................................................................. 4
   HPCSA Ethical Rules, which stakeholders have recommended for “review” ..... 7

9. Alternative Reimbursement Mechanisms ......................................................................................... 9

10. Employment of medical practitioners by profit-making entities ............................................. 10

11. Clinical Coding ............................................................................................................................... 11

12. Conclusion ....................................................................................................................................... 12

Appendix A – Declaration of Geneva ............................................................................................... 14

Appendix B - International Code of Medical Ethics .......................................................................... 15

Appendix C - Declaration of Seoul .................................................................................................... 16

Appendix D – Declaration of Madrid ................................................................................................. 17
1. Introduction

The South African Medical Association (SAMA) is pleased to contribute comments in response to the requests following the Health Market Inquiry (HMI) Seminars to discuss Funder and Hospital market concentration, and supply-induced demand and excessive utilisation.

Given the short timelines for submission, SAMA has chosen to focus on our main areas of concern related to the draft HMI recommendations and the comments made by stakeholders other than healthcare practitioner groups at the seminars.

We also make reference to previous SAMA submissions where appropriate.

We remain concerned that the excessive power imbalance between the hospital and funding groups and practitioners will play out badly for patients, who are at the heart of the intentions behind the HMI.

SAMA is in favour of the improvement of monitoring of clinical outcomes and quality of care.

Our concerns remain with proposals to permit employment of medical practitioners by profit-making entities, as well as proposals for alternative reimbursement models, which we believe in a very power-imbalanced environment, will lead to a compromise of clinical autonomy for patients and a threat to the quality of care delivered to patients.

We also believe that a review of the Health Professions Council Ethical Rules may be valuable, however, only in the context of full cognizance of what these rules are intended to achieve, and how they are positioned to protect patients.

We do not believe that the solution to failed enforcement of good regulation is to change the regulation. Good regulation should be adequately enforced.

2. Local and international medical ethics standards and medical professionalism

SAMA notes with concern that fact that the Health Professions Council has not made written submission in response to the HMI Provisional Report, nor to the seminars held
in April. We therefore feel it necessary to bring to the HMI’s attention several national and ethical statutes, which are aimed at protecting patients.

In the SAMA response to the HMI Provisional Report, SAMA expressed concerns with regard to submissions to the HMI as well as comments made by various stakeholders regarding it being necessary that practitioners should be “influenced”, “controlled” and that protocols, approaches and functions should be “enforced” on practitioners, presumably by the hospital groups, and healthcare funders who made these statements (Table 2, pg. 40 of the SAMA submission to the HMI Provisional Report, October 2018).

Declaration of Geneva and International Ethical Codes

The World Medical Associations (WMA) Declaration of Geneva (a modernised version of Hippocratic Oath) adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, and lastly amended by the 68th WMA assembly Chicago, USA, In October 2017, requires doctors to consider the health and wellbeing of their patients first. The whole declaration is included as Appendix A.

The international code of medical ethics (ICOME) was subsequently adopted in 1949 by the WMA and currently undergoing major revision. This is included as Appendix B.

The ICOME is a code based on the Declaration of Geneva and the main goal is to establish the ethical principles of the physicians worldwide, based on his duties in general, to his patients and to his colleagues.

“A PHYSICIAN SHALL

- always exercise his/her independent professional judgment and maintain the highest standards of professional conduct
- not allow his/her judgment to be influenced by personal profit or unfair discrimination
- Deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.
- *Strive to use health care resources in the best way to benefit patients and their community.*

- *Not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.*”

The majority of the International Physician Regulatory bodies including the local Health Professions Council develop their Ethical rules based on these two codes.

We would like to bring to the attention of the UK Competition and Market Authority (CMA) private sector inquiry¹.

The CMA order prohibits clinicians from requesting, agreeing to receive or accepting, any direct incentive from private hospital providers to give preference to their facilities, when treating patients or referring patients for treatment or tests. Equally, private hospitals providers are prohibited from offering inducements to procure referring clinicians, to give preference to their hospitals.

Furthermore, the order requires transparency in shareholding and publication of doctors who have share of the schemes.

These issues, although raised in the HMI report, did not find any room in the final recommendations, in spite of the fact that the HPCSA already seeks to address these issues in its ethical rules.

The World Medical Association Declaration of Seoul of Professional Autonomy and Clinical Independence, as amended by the 69th World Medical Association General Assembly in October 2018, reaffirms the Declaration of Madrid on professionally led regulation²³.

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Declaration of Seoul, 2018:

“The World Medical Association recognises the essential nature of professional autonomy and physician clinical independence, and states that:

1. Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. Professional autonomy and independence are essential for the delivery of high quality health care and therefore benefit patients and society.

2. Professional autonomy and clinical independence describes the processes under which individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals.” …

6. Priority setting and limitations on health care coverage are essential due to limited resources. Governments, health care funders (third party payers), administrators and Managed Care organisations may interfere with clinical autonomy by seeking to impose rules and limitations. These may not reflect evidence-based medicine principles, cost-effectiveness and the best interest of patients. Economic evaluation studies may be undertaken from a funder’s not a users’ perspective and emphasise cost-savings rather than health outcomes.

7. Priority setting, funding decision making and resource allocation/limitations processes are frequently not transparent. A lack of transparency further perpetuates health inequities.

8. Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. Professional autonomy allows physicians to help patients make informed choices, and supports physicians if they refuse demands by patients and family members for access to inappropriate treatments and services”

The full declarations are attached in Appendix C and D. These are the key international documents, which reflect similar concerns to those highlighted by SAMA in previous submissions.

Medicine is highly complex. Through lengthy training and experience, physicians become medical experts weighing evidence to formulate advice to patients.
SAMA agrees that professional autonomy is limited by adherence to professional rules, standards and the evidence base.

But we support that these should also be determined and monitored only by medical professionals adhering to the same ethical standards as their colleagues.

The delivery of health care by physicians is governed by ethical rules, professional norms and by applicable law. Physicians contribute to the development of normative standards, recognizing that this both regulates their work as professionals and provides assurance to the public.

SAMA believes that the Health Professions Council Ethical Rules have been drawn up with international best practice in mind and serve to ensure that the health and wellbeing of the society is a first consideration for the doctors, the clinicians judgement is not influenced by profit or unfair discrimination, prohibition of perverse incentives and the preservation of both patient and practitioner autonomy.

For entities other than professional societies or practitioner groupings, to be calling for the HPCSA ethical rules to be reviewed is an attack on the ethics of the medical profession of South Africa, by those who do not subscribe to or appreciate the intentions behind medical ethics. We do however believe that HPCSA can regulate profession better by ensuring that the ethical rules are adhered to. For example: Perverse relationship between hospitals and practitioners require further scrutiny and clear guidance from the HPCSA.

HPCSA Ethical Rules, which stakeholders have recommended for “review”.

Most commonly cited as standing in the way of new patient care models as Ethical Rules 7(4) and 7(5)\(^4\).

Although there were again calls at the HMI Seminars in April, for the HPCSA ethical rules to be reviewed, as they stand in the way of innovation and multi-disciplinary practice, SAMA understands this quite differently.

The HPCSA Ethical Rules 7 and 8 Read as follows:

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“Fees and commission

7. (1) A practitioner shall not accept commission or any material consideration, (monetary or otherwise) from a person or from another practitioner or institution in return for the purchase, sale or supply of any goods, substances or materials used by him or her in the conduct of his or her professional practice.

(2) A practitioner shall not pay commission or offer any material consideration, (monetary or otherwise) to any person for recommending patients.

(3) A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under-service, over-service or over-charge patients.

(4) A practitioner shall not share fees with any person or with another practitioner who has not taken a commensurate part in the services for which such fees are charged.

(5) A practitioner shall not charge or receive fees for services not personally rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or locum tenens.

(6) A practitioner shall explain to the patients the benefits, costs and consequences associated with each service option offered.

Partnership and juristic persons

8. (1) A practitioner may practise in partnership or association with or employ only a practitioner who is registered under the Act and who is not prohibited under any of the annexures to these rules or any ethical rulings from entering into such partnership or association or being so employed: Provided that, in the case of employment, the practitioner so employed either provides a supportive health care service to complete or supplement the employing practitioner's healthcare or treatment intervention or is in the same professional category as the employing practitioner.

(2) A practitioner shall practise in or as a juristic person who is exempted from registration in terms of section 54A of the Act only if such juristic person complies with the conditions of such exemption.

(3) A practitioner shall practise in a partnership, association or as a juristic person only within the scope of the profession in respect of which he or she is registered under the Act.
(4) A practitioner shall not practise in any other form of practice which as inherent requirements or conditions that violate or potentially may violate one or more of these rules or an annexure to these rules.

**Sharing of Rooms**

8. A practitioner shall not share his or her rooms with a person or entity not registered in terms of the Act

The HPCSA rule 3 can prevent multi-disciplinary practice, or professionals this needs to be amended with caution. It makes perfect sense that doctors work with nurses (Registered with Nursing Council). On the other hand, allowing pharmacists and doctors to share offices and engage in multidisciplinary practices may result in collusive and harmful behaviour.

We believe the rules generally discourage the, influence by entities outside of the registered clinical professions and this principle should be promoted by the HMI

The ethical rules also translate into the HPCSA Policy on Business practice⁵. This document dictates several criteria to address corporate involvement and employment of practitioners by entities not registered in terms of the Health Professions Act. It is very clear that this are drawn up with the prime directive of preserving clinician autonomy and protecting practitioners and patients from perverse incentives which might arise as a result of business relationships.

### 9. Alternative Reimbursement Mechanisms

There are various types of alternative reimbursement mechanism, “alternative” referring to something other than the standard fee for service (FFS) payment mechanism to which the South African private healthcare system has become accustomed: Modified FFS, event-based, global fees and capitation mechanisms encompass the most commonly examined of these possibilities.

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SAMA has produced a discussion document on these for internal consideration by out Private Practice and Human Rights Law and Ethics Committees.

There IS NO single ideal payment mechanism and all alternative reimbursement mechanisms can potentially threaten patient quality of care and professional autonomy, if not implemented in an environment where these can be protected against desires to reduce costs.

SAMA does not believe that the current balance of power in the private health sector would allow for this in most instances. In most instances, ARM agreements are developed and “enforced” by funders or hospital groups, and where practitioners refuse to participate it is because of the fact that these compromise clinical autonomy, potentially quality of care, and even patient safety in some cases.

We have also watched as the South African Anaesthesiology Society’s Alternative Reimbursement proposals, which were developed by a clinician grouping, and maintained sufficient clinical autonomy and quality standard, to garner approval by the Health Professions Council, have failed to win much support or participation by funding entities.

SAMA asserts that prior to any of these kinds of arrangements becoming the norm, the balance of power between clinicians, and corporate funding and hospital groups’ needs to be addressed.

SAMA has indicated that we would be in favour of a regulated tariff determination process, which would aim to set minimum tariffs through a multi-lateral negotiation process.

10. Employment of medical practitioners by profit-making entities

SAMA has openly disagreed with the concept of employment of doctors by the current private sector corporate entities, with whom our members deal. SAMA, also operating as a trade union for its doctors employed in the public sector, has received criticism for its stance of employment of doctors in the private sector.
It is important for us to emphasise that the nature of the potential employer is critical (in the case of the private sector and submissions received to date, this would inevitably be a corporate, profit-making entity).

This employment environment is fundamentally different to that of a constitutionally based service provision entity funded by public sector monies, and based on the rights of people to access to healthcare.

We have been particularly perturbed by the language used in submissions to the HMI to advocate in favour of practitioner employment by profit-making corporate entities (Table 2, Page 40 of the SAMA submission to the HMI Provisional Report).

We believe that doctors will inevitably be exposed to conflicts in dual loyalty to employers’ profit-driven motives, and their patients’ healthcare requirements.

We additionally believe that full employment is not necessary if other innovative business models can be explored.

Analyses of Medicare expenditure in the United States of America have indicated that hospital-employed physicians can actually cost the scheme more. Although this first report was conducted by a physician advocacy organisation, an earlier report by Auditors General of 16 US States argued the same thing.

11. Clinical Coding

The OECD technical report submitted to this Inquiry, confirmed that professionals worldwide play a role in development of coding and that there is a separation between development of codes and price determination. SAMA strongly believes that coding must remain the intellectual pursuit of clinical professionals and clinical coding experts.

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We also believe that decisions on clinical coding need to be separated from tariff negotiation processes, as technically these decisions are fundamentally different and require different expertise.

Clinical coding is a common clinical language to express clinical diagnosis, interventions and severity in a computerised system.

From an outcomes point of view, SAMA would support that common standards for coding must be established and followed by all providers and case mix adjustment mechanisms need to be agreed to and applied.

Currently, SAMA is only the custodian of a manual of codes for medical practitioners, not for the entire registered health practitioner grouping. The allied health professional groups have their own codes, as do nurses and pharmacists. Expertise in this area is specialised within each discipline.

We do not believe that funders of hospital groups should lead the processes pertaining to clinical coding, because of the incentives at play. Therefore, HMI must clearly make recommendations with regards to clinical coding.

12. Conclusion

SAMA has not aimed to repeat assertions and positions, which we have submitted in multiple previous submissions to the HMI.

We do feel that many of the calls made by non-professional corporate entities, who do not understand or appreciate the gravity of ethical and professional standards, are misplaced.

That said, SAMA has voiced our support for attempts and regulations to enhance improved development of clinical guidelines, monitoring and reporting of quality indicators and patient outcomes, and multi-disciplinary team approaches to care. We are also aware of the merits and potential pitfalls of ARMs.

However, we do believe that the HPCSA could be enforcing existing legislation and ethical rules better. The failure of enforcement of good rules does not require a review of the rules. It requires improvement in enforcement.
We believe the proposals from corporate entities serve only to enhance the already dominant power in the hand of these groups and urge the HMI NOT to pursue such policy and legislative directives.

Dr Angelique Coetzee
SAMA National Chairperson
Appendix A – Declaration of Geneva

WMA DECLARATION OF GENEVA

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017

The Physician’s Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.
Appendix B - International Code of Medical Ethics

WMA INTERNATIONAL CODE OF MEDICAL ETHICS


DUTIES OF PHYSICIANS IN GENERAL

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<th>A PHYSICIAN SHALL</th>
<th>always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.</th>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>respect a competent patient's right to accept or refuse treatment.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>not allow his/her judgment to be influenced by personal profit or unfair discrimination.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.</td>
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<td>A PHYSICIAN SHALL</td>
<td>deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>respect the rights and preferences of patients, colleagues, and other health professionals.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>certify only that which he/she has personally verified.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>strive to use health care resources in the best way to benefit patients and their community.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>seek appropriate care and attention if he/she suffers from mental or physical illness.</td>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>respect the local and national codes of ethics.</td>
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DUTIES OF PHYSICIANS TO PATIENTS

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<tr>
<th>A PHYSICIAN SHALL</th>
<th>always bear in mind the obligation to respect human life.</th>
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<tr>
<td>A PHYSICIAN SHALL</td>
<td>act in the patient's best interest when providing medical care.</td>
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WMA DECLARATION OF SEOUL ON PROFESSIONAL AUTONOMY AND CLINICAL INDEPENDENCE

Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008
And amended by the 69th WMA General Assembly, Reykjavik, Iceland, October 2018

The WMA reaffirms the Declaration of Madrid on professionally-led regulation.

The World Medical Association recognises the essential nature of professional autonomy and physician clinical independence, and states that:

1. Professional autonomy and clinical independence are essential elements in providing quality health care to all patients and populations. Professional autonomy and independence are essential for the delivery of high quality health care and therefore benefit patients and society.

2. Professional autonomy and clinical independence describes the processes under which individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals.

3. Medicine is highly complex. Through lengthy training and experience, physicians become medical experts weighing evidence to formulate advice to patients. Whereas patients have the right to self-determination, deciding within certain constraints which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations.

4. Physicians recognize that they must take into account the structure of the health system and available resources when making treatment decisions. Unreasonable restraints on clinical independence imposed by governments and administrators are not in the best interests of patients because they may not be evidence based and risk undermining trust which is an essential component of the patient-physician relationship.

5. Professional autonomy is limited by adherence to professional rules, standards and the evidence base.

6. Priority setting and limitations on health care coverage are essential due to limited resources. Governments, health care funders (third party payers), administrators and Managed Care organisations may interfere with clinical autonomy by seeking to impose rules and limitations. These may not reflect evidence-based medicine principles, cost-effectiveness and the best interest of patients. Economic evaluation studies may be undertaken from a funder’s not a users’ perspective and emphasise cost-savings rather than health outcomes.

7. Priority setting, funding decision making and resource allocation/limitations processes are frequently not transparent. A lack of transparency further perpetuates health inequities.

8. Some hospital administrators and third-party payers consider physician professional autonomy to be incompatible with prudent management of health care costs. Professional autonomy allows physicians to help patients make informed choices, and supports physicians if they refuse demands by patients and family members for access to inappropriate treatments and services.

9. Care is given by teams of health care professionals, usually led by physicians. No member of the care team should interfere with the professional autonomy and clinical independence of the physician who assumes the ultimate responsibility for the care of the patient. In situations where another team member has clinical concerns about the proposed course of treatment, a mechanism to voice those concerns without fear of reprisal should exist.

10. The delivery of health care by physicians is governed by ethical rules, professional norms and by applicable law. Physicians contribute to the development of normative standards, recognizing that this both regulates their work as professionals and provides assurance to the public.

11. Ethics committees, credentials committees and other forms of peer review have long been established, recognised and accepted by organised medicine as ways of scrutinizing physicians’ professional conduct and, where appropriate, may impose reasonable restrictions on the absolute professional freedom of physicians.

12. The World Medical Association reaffirms that professional autonomy and clinical independence are essential components of high quality medical care and the patient-physician relationship that must be preserved. The WMA also affirms that professional autonomy and clinical independence are core elements of medical professionalism.
Appendix D – Declaration of Madrid

WORLD MEDICAL ASSOCIATION

WMA DECLARATION OF MADRID ON PROFESSIONALLY-LED REGULATION

Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009

The collective action by the medical profession seeking for the benefit of patients, in assuming responsibility for implementing a system of professionally-led regulation will enhance and assure the individual physician's right to treat patients without interference, based on his or her best clinical judgment. Therefore, the WMA urges the national medical associations and all physicians to take the following actions.

1. Physicians have been granted by society a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on the best interests of their patients without undue outside influence.

2. As a corollary to the right of professional autonomy and clinical independence, the medical profession has a continuing responsibility to be self-regulating. Ultimate control and decision-making authority must rest with physicians, based on their specific medical training, knowledge, experience and expertise.

3. Physicians in each country are urged to establish, maintain and actively participate in a legitimate system of professionally-led regulation. This dedication is to ultimately assure full clinical independence in patient care decisions.

4. To avoid being influenced by the inherent potential conflicts of interest that will arise from assuming both representational and regulatory duties, National Medical Associations must do their utmost to promote and support the concept of professionally-led regulation amongst their membership and the public.

5. Any system of professionally-led regulation must ensure
   a) the quality of the care provided to patients,
   b) the competence of the physician providing that care and
   c) the professional conduct of physician.

   To ensure the patient quality continuing care, physicians must participate actively in the process of Continuing Professional Development in order to update and maintain their clinical knowledge, skills and competence.

6. The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly recognized and reported. The physicians who have erred must be appropriately disciplined and where possible be rehabilitated.

7. National Medical Associations are urged to assist each other in coping with new and developing problems, including potential inappropriate threats to professionally-led regulation. The ongoing exchange of information and experiences between National Medical Associations is essential for the benefit of patients.

8. An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self-serving or internally protective of the profession, and the process must be fair, reasonable and sufficiently transparent to ensure this. National Medical Associations should assist their members in understanding that self-regulation cannot only be perceived as being protective of physicians, but must maintain the safety, support and confidence of the general public as well as the honour of the profession itself.