SAOA SUBMISSION: HMI SEMINARS:

INTRODUCTION

The SAOA thanks the HMI Panel for the opportunity to comment primarily in response to presentations and engagement at the HMI Seminars held on 9, 10 and 12 April 2019.

As agreed, on the last day of the Seminar, stakeholders are invited to make succinct submissions on issues debated during the 3 days, with particular focus on the following:

- Facilities market concentration;
- Funders market concentration;
- Supplier Induced Demand and overutilization.

This submission places emphasis on alleged supplier induced demand and utilisation.

GENERAL COMMENT

The SAOA, as a participating stakeholder, has invested a great deal of time, effort and expense to ensure a comprehensive submission to the HMI during the Public Hearings.

The SAOA wishes to record our disappointment that there was no reference to issues raised by the SAOA within the Provisional Report, relating specifically to relationships between providers, schemes and Designated Service Providers.

It is significant to note that a number of the very same concerns were raised during the last day of the Seminar by general practitioners describing treatment of practitioners by funders and DSP’s. These concerns, are once again, summarised below (see ‘Key Concerns pertaining to DSP participation’).

Inquisitorial Role of HMI

It is also of concern to note that subsequent to the presentation by the SAOA at the Public Hearings, which drew attention to the structure and conduct of a particular DSP, by example, there was no feedback given to the SAOA but the network concerned has officially informed funders and other stakeholders that they were given a ‘clean bill of health’ by the HMI (see attachment).

It would be appreciated if the HMI Panel could confirm whether such ‘clean bill of health’ was indeed granted to the DSP concerned or not.

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SAOA POSITIONS

The following are the positions of the SAOA which are considered to have relevance to the HMI, in general, as well as in response to engagements that took place at the Seminars.

Role of the DSP’s

Despite perceptions by particularly the funders, the DSP’s or Provider Networks do not act on behalf of providers and thus, are not to be regarded as representing providers in their negotiations. In practical terms, the primary customer of the DSP is, in fact the funder, not the practitioner.

Power Asymmetry

For fear of losing income and patients, providers are forced and coerced to participate in network arrangements, often to the detriment of their autonomy and their practices.

Sustainability of practices remains a priority factor and thus pricing models and benefit design are to take cognisance of this critical issue.

Presentations by schemes and hospital groups have applauded the concept of DSP’s as has the HMI Panel in the Provisional Report. Indeed, the DSP, in principle, provides value but the detrimental consequences to providers due implementation methods appears to have been lost within the HMI process.

Key Concerns Pertaining to DSP Participation

- Non-accreditation of entities offering managed care services by the relevant authority which is in violation of the Medical Schemes Act.
- Abuse of dominance needs to be addressed whereby providers are coerced to provide services in accordance with funder-DSP contractual obligations for fear of losing patience and income.
- Inducement to participate with a competing entity is to be reviewed
- There must be an equitable opportunity for health care providers to participate in a DSP arrangement;
- The health of patients must be the priority at all times;
- The autonomy and professional discretion of practitioners must be respected;
- The choice of provider by the patient is to be respected;
- A Preferred Provider arrangement should be considered in the literal sense i.e. no exclusivity arrangements
- There should be a reasonable range of choice of product, where applicable, to accommodate the clinical and functional needs of patients;
- Registered practitioners will always be accountable for any advertising instituted by the DSP and thus liable for touting or canvassing instituted by the DSP;
- Should fees for services rendered exceed the agreed DSP benefit, any excess payment must be shown on the claim to the medical scheme concerned (Balanced Billing Not Split Billing). Practitioners should not be compromised if fees exceed the benefit if the patient is willing to pay the difference.
DSP’s often take further discounts off an already discounted capitation tariff from claims submitted by practitioners for professional services rendered. This is a case of double jeopardy in that the provider charges a discounted fee, as per contractual obligation, and thereafter the DSP takes a further discount. The DSP benefits twice in that they are paid a capitation fee that includes allowances for administration but, in addition, further discount is taken from the provider.

Fraud, Waste and Abuse.

The SAOA strongly opposes any form of fraud, waste and abuse. However, the rights of practitioners are also to be respected at all times.

RESPONSES TO ISSUES RAISED

Providers – The Villains?

Indeed, there was reference to incentivising providers of care at the Seminar on the basis of quality outcomes. However, the overriding message is that providers are to be disciplined. They have been made the villains of the system and are being held mainly responsible for the ills of the private health system. Optometrists are trained and highly skilled professionals, as are other healthcare providers, and should be respected as such.

They do need structure; they do need organization and through this the delivery system can be effectively managed.

Disciplining providers is disempowering.

Competition Between Providers

In the experience of the SAOA, the notion that successful DSP networks leverage competition between providers is not strictly true. The competition, in general, takes the form of an ‘arm wrestle’ between the networks themselves.

The notion that providers only compete on quality to a limited extent is also rejected. The key competitive factor remains price. It could be argued that DSP arrangements to a large degree, particularly in a capitation scenario, very much erodes quality of care due to the pricing factor.

It is acknowledged that funders are forced to contract with DSPs in a very piecemeal fashion. There is a need for a unified approach.

Quality Measurement

It is acknowledged that there is no definition of how to measure and compute quality. The regulator should oversee the development of a comprehensive quality methodology to improve the framework.
In practical terms, there is a need to standardise measurements of quality across the industry and standardising agreements with DSPs.

**Private Sector/Public Sector Partnerships**

The SAOA supports the principle of PPP’s to promote accessible, affordable and quality care to all communities.

**Ministerial Powers**

The SAOA shares concern, as raised at the Seminar, if in fact the case, that the Minister of Health does not have the jurisdiction or power to give effect to the recommendations of the HMI.

**Tariff Determination Process**

As stated above, the SAOA is supportive of the establishment of a Supply Regulator to accommodate fair fee negotiations in addition to the provision of practice numbers and a hierarchical coding structure for professional procedures.

The SAOA is particularly in favour of bilateral negotiations, primarily between the professions, represented by the professional associations and funders, to establish maximum prices on the basis of collective bargaining.

**Inability of Funders to Discipline Providers**

The allegation that funders are unable to discipline providers is not only rejected but is also unfounded. The Forensic units of funders are extremely active, to a fault, to curtail costs and utilisation.

In essence, providers of care are regulated by the HPCSA but find themselves at the mercy of funders, via their forensic units, to sign acknowledgements of debt and/or face punitive measures which include withholding of payment for claims received, cessation of direct payment, clawbacks, etc.

**Primary Care.**

The primary health system within SA Healthcare is indeed poorly developed. There is a need for structural change to be accountable for general value.

**Price versus Utilisation**

Health care inflation is not necessarily a price issue; information available indicates it is a utilisation issue.

A team-based approach is needed which delivers on outcomes.
CONCLUSION

The SAOA is appreciative of the opportunity to express views and provide inputs relating to the HMI Seminars and looks forward to issues raised receiving the desired attention by the HMI Panel.

Yours Sincerely,

Dollars Boloka
SAOA PRESIDENT