Health Market Inquiry Panel
Health Market Inquiry

26 April 2019

c/o: EnikaP@compcom.co.za

Dear Panel Members,

RE: SUBMISSION BASED ON STAKEHOLDER ENGAGEMENTS AT THE FUNDER CONCENTRATION, FACILITY CONCENTRATION AND SUPPLIER INDUCED DEMAND SEMINARS

The South African Society of Anaesthesiologists (SASA) presented at the Supplier Induced Demand Seminar of 12 April 2019. We also attended and, where relevant, participated in the other two seminars held at this time. We thank the Panel for the engagement facilitated through these sessions and for the opportunity to make a final submission on these specific topics.

SASA’s presentation focussed specifically on the proposed remedy of amendments to the HPCSA Ethical Rules. While we certainly support the need for change and innovation, we urged caution in how these changes are applied, so as to ensure a patient-centric approach that ensures safe and effective patient care. Most importantly amendments of the HPCSA rules in favour of competition (and driving to decrease cost) should not be at the expense of quality (including safety, efficiency and effective patient centred care). SASA reiterates that it sees quality as including the tenets of affordability, efficiency and access.

Our caution and submission are not borne out of a protectionist attitude or opposition to innovation or change. We actively support cost-effective healthcare and attach our position statement in this regard.
Rather the caution is as a direct result of real clinical experience and actual reports of harm as a result of a lack of regulatory oversight and policing. The relative absence of this regulatory aspect results in an absolution of “for profit” agendas to be accountable and responsible to patients and their outcomes. This experience and fact is unique and peculiar to environments that either have good regulatory laws but no policing and implementation thereof, or where no regulation exists. We have borne witness to direct patient harm in both the public and private sector as a result.

This submission only deals with the impact of this “secondary” regulatory failure in the private sector.

Taking cognisance of this “secondary” regulatory failure, consideration of what currently exists to protect patients from potential “competitive” or “for profit” harm is important. There is no question, in our opinion, that those individuals empowered and encumbered with patient care at the front line, those that are answerable directly to the individual patient, are the party most invested in the patient care and outcome (outside of the patient and his/her family themselves). While there exist outliers in every sector in society, the vast majority of healthcare professionals who truly believe in their accountability and responsibility, will continue to defend best quality patient care in service of patient health outcomes. Healthcare professional responsibility and accountability is underscored in majority by two regulators – the Health Professions Council of South Africa (HPCSA) and the South African Nursing Council (SANC). It is these regulator rules that remain the bastion and protection against nefarious agendas. By ensuring ethical standards and care guidelines are in place, professionals are not only accountable and responsible within these rules, but may use these rules to reasonably defend “innovative” practices that are likely or already have caused patient harm. We acknowledge and agree that these regulators too may suffer from regulatory implementation and policing failure. That said, within the professional environment there remains a moral incentive (as a result of training and direct patient interaction), social incentive (collegial and societal peer review) and financial incentive (loss of patients with the knowledge of poor outcome, administrator and funder oversight and
audit) coupled with these published rules that provides a secondary “policing” role in the private sector.

While all the above is arguably not a panacea and certainly does not result in absolute or best protection (effective regulators are clearly best), an overhaul of regulatory rules as they govern professionals should be undertaken carefully, with a clear understanding of the unintended consequences that may occur as a result. The healthcare sector in both the public and private space is awash with evidence where cost savings alone or ignoring current rules have resulted in direct patient harm and care. This results in a further financial cost to the country, more often than not.

We submit that there are HPCSA rules that are important to review and amend. In majority these relate to certain logistics of practice rather than ethical rules which govern the ethics of patient care. It is important to appreciate that the interaction of healthcare professionals is complex, may include power dynamics and may not empower those with direct accountability and responsibility to patients to act as custodians of quality patient care (where for profit or cost agendas are at odds with quality). On this basis our request and suggestion is that any review of ethical or other professional regulatory rules ensure that “front-line” clinicians engaged in active patient care, HPCSA and SANC representatives and those with insight into the dynamics of patient care in the private sector are well engaged and suggestions considered before any amendment is considered and implemented. It is vital to well consider unintended consequences for patient care at every step and level.

In putting forward this argument, SASA presented a model developed by the Society that we argue provides an effective way forward even within the current HPCSA rules. In our opinion this approach and contract provides an effective, ethical and patient centred approach that is novel and addresses multiple “failures” that exist in the private and public healthcare sector. It enables alternative reimbursement models while ensuring clinicians, administrators, funders and facilities are contractually accountable to patients, all participants in the patient care journey and to regulators and within a contracted team based
approach to the patient healthcare “event”. As informally requested, this submission also includes copies of the contractual arrangements underpinning this model and currently in place with Discovery Health. This consists of three separate components. The first is a contract between the funder and the clinical service provider. Second - this is supported by a series of annexures that define the specific terms of engagement, by specific episodes of care type. The reason these elements are outlined as annexures are two-fold. Firstly, this allows the headline agreement to provide overall contractual governance and for additional care episodes to be more easily added. This also allows for the financial aspects of the agreement to remain outside of the influence and purview of the Society itself as, by law, these may only be agreed between the funder and individual healthcare practitioner. The final component of the agreements is the contract between the funder and the Society itself. This final contract ensures those removed from direct patient care, the clinician’s peers with clinical and logistical insight as well as those representing patient interests and finances – administrators and funders – are, too, accountable and responsible for quality oversight and review. This contract outlines the arrangements for oversight and accountability, information sharing and peer review.

SASA has invested considerable time and money into the development of this proposed way forward. However, we have done so in the interests of patient care and have attached no charge for the use of these agreements. Any administration fees will be used to cover direct costs only so as to enable the arrangements. SASA has made these agreement formats available to all healthcare practitioner, facility or funder groups who have requested copies.

SASA has no specific expertise on the models or arguments put forward on any of the other issues relating to funder concentration, facility concentration or supplier induced demand and have no comment on the remedies relating to the first two specifically. On the last point, we support the remedies proposed by the Health Market Inquiry, regardless of the view of the quantum of supplier induced demand. We argue that a more effectively regulated system, with proper workforce planning and rational tariff benchmarking will only benefit the
provision of healthcare services to the country. It is important to ensure that regulatory oversight and policing capacity are well catered for first and prior to interventions that are exposed to unintended consequences and agendas that do not protect patient quality care. Our support should also, of course, take into account our caution with regards to how these changes are implemented.

Although we do not have specific expertise or comments on the issues of facility or funder concentration, our members certainly understand the healthcare sector as a whole, being entrenched in its delivery at the coal-face and “front line”, as it were. As such, SASA does wish to make some specific overall comments on the discussions that took place at the seminars.

Much of the debate centred on the tighter and more effective management of the current hospice-centric model of benefit design and delivery, as well as the power dynamics within this model. We believe that, unfortunately, so long as there are trust deficits and power imbalances between the facilities, funders and clinicians, a deficit in an effective regulatory oversight and inspectorate (policing), and without transparency in terms of “for profit” agendas, we will always experience outcomes such as Supplier Induced Demand.

Further, our experience is that mechanisms of control developed from a funding or actuarial perspective, without the considerable input of the clinicians themselves and the patient at the centre, lead to perversities and patient care compromise, often without a related saving or benefit accruing. We have a multitude of real examples of this in practice. The clinicians need to be actively involved in design and, especially, in the definition of care pathway and clinical guideline development. We have a responsibility and work to be done here. We accept that this has not always been driven sufficiently by the clinicians, and we are doing our very best to fulfil this mandate. Any regulatory interventions should ensure both academic and treating clinicians are mandated to participate in development and change in the sector and not merely “consulted” and an ability to dispense with guidance and advice.
SASA also notes the considerable emphasis placed on the possible direct employment of doctors (specifically specialists) made by some facility and some funder groups. While SASA noted, also, the concerns raised by the Panel with regards this issue, we still feel it is important to reiterate our research and views on this matter. South Africa is an extremely resource constrained environment and there is a decided shortage of anaesthesiologists, and specifically in our public sector and non-metropolitan areas. This is not unique to our speciality but pervasive among all healthcare workers in the country and supported by statistical evidence undertaken by independent actuarial analysts. When surveying our members, it became clear that less than 20% of SASA’s private sector members would consider accepting employment by a facility group. The reasons given underpin the points made above about the trust deficits and power imbalances. With no effective regulator for the sector, enhanced power of for-profit entities over the clinicians cannot possibly lead to better patient care or sustainably so. Further, SASA’s survey showed that nearly 70% of our public sector members WOULD consider direct employment in private facilities. The consequence of this differential would devastate service to the vast majority of the country. SASA also noted a significant concern with regards to the impact of direct employment on competition. One example of many that would likely result - with anaesthesia being a constraint, the facility that manages to recruit the bulk of the anaesthetists in an area has effectively created an impenetrable barrier to entry for any other facility group (regardless of acuity of care, as anaesthetists work across all). In some regions, there are very few practitioners and this remains a very real possibility. It is exactly this intent that has also led to a race for specialists by some American hospital groups, with the net result of an increased price of healthcare services.

We refer the HMI to a Harvard Business Review article released in May 29th, 2018 entitled “Do Most Hospitals Benefit from Directly Employing Physicians”. This article gives a good review and experience from other HMI referenced systems that describes the real shortfalls and “for profit” agendas that underscore clinician employment as well as a clear effective decrease in workhours available from a workforce. In an extremely workforce stressed country (number wise) we argue this approach at this time would be ill-advised.
Despite private facilities enabled to directly employ nursing staff, evidence of decreased staff:patient ratios, compromise on qualifications and operating wards and environments to decrease costs at the expense of patient care, without regulatory oversight and policing, are already clear indications how direct employment (and effective disempowerment) of clinicians would impact the healthcare system.

That all said, we are also concerned that we are looking for ways to tighten an already relatively tight management of an existing system. Not that improvements cannot be achieved, but that these improvements would be incremental in the face of a bigger issue. As such, we strongly support the submissions and comments from a number of clinician-driven stakeholders (SAMA, Brian Ruff, etc.) that the entire system needs to shift focus. Although we are a hospice-centric profession, our view is that we would serve both the country and the patient best by working to prevent patients from needing hospitalisation in the first place, or certainly be enabling a reduced acuity of care.

There are many barriers to achieving this. That includes both the current provision and distribution of general practitioners and allied health workers and the remuneration models currently in place. It also includes the level of ward care and the quality control of alternate facilities. Medical Scheme plan design certainly does not enable such options, nor does there seem to be much desire to make such changes. For example, SASA has been proposing pre-operative clinics for the better optimisation (or exclusion) of patients for over four years now. The current system of remuneration simply does not make viable operating such a service even at a break-even point for clinicians. Schemes are positive about such proposals, but actioning them is extremely slow and we are even yet to reach a point in any discussion where practical implementation issues are addressed.

Please note that although a shift in focus is needed, we also cannot lose the catastrophic care cover that schemes provide, as it is this that the consumer is reliant upon. It cannot be a replacement of one for the other, but a shift in primary focus to primary and preventative care that will, we strongly argue, manage the costs of the healthcare system more effectively.
than small savings to be found in, for example, some of the alternative reimbursement models. We have also seen instances where the cost of the additional management exceeds the savings identified.

The changes needed require stewardship, leadership and effective regulatory oversight. This is, as has been noted a number of times in many submissions and forums, in short supply. SASA participates actively in forums such as the CMS’s Review of the PMB Benefits and is disheartened by the processes being followed and the progress being made, despite a relatively unified desire to see change and clarification here, as an example.

We hope, therefore, that the final HMI report and the recommendations contained therein are taken forward proactively and effectively by the healthcare leadership within South Africa.

Should the Panel have any further queries or engagements it would like to have with the SASA members, please do not hesitate to ask. We remain available for any such discussion.

Yours sincerely

Ms. Natalie Zimmelman
SASA CEO

CC The SASA Council