THE SOUTH AFRICAN MEDICAL ASSOCIATION

SUBMISSION TO THE COMPETITION COMMISSION MARKET ENQUIRY INTO

PRIVATE HEALTHCARE

IN RESPECT OF THE INVITATION TO PARTICIPATE IN A SEMINAR ON TARIFF DETERMINATION (26 September 2017)

HIGH LEVEL COMMENTS

Date: 9 October 2017

1 Introduction

The South African Medical Association (SAMA) thanks the Competition Commission Private Health market Inquiry for the opportunity to submit in response to the "Invitation to participate in a seminar on tariff determination" issued by the HMI on 26 September.

As a voluntary membership organization, SAMA does not prescribe to its members how to practice their profession, nor do we prescribe any directives or guidance on tariffs to be charged for medical services.

Prior to the Competition Commission's findings in the early 2000s, that it was in contravention of section 4(1)(b)(i) of the Competition Act No 89 of 1998, SAMA had, with the Hospital Association of South Africa (HASA), the South African Dental Association (SADA) and the Board of Healthcare Funders (BHF), set about collectively bargaining tariffs which were set as a guideline for its members and published in the "Benchmark Guide to Fees for Medical Services".

Since the Consent order entered into by the above organization in 2004 – this activity has ceased and SAMA continues to publish only a manual of clinical billing codes, today called the Medical Doctors Coding Manual (MDCM).

SAMA views the current tariff environment to be problematic for medical schemes, practitioners and, most importantly, patients and we are pleased that the HMI now looks to ways to remedy the current situation as presented throughout the HMI inquiry so far.

2 High level comments to proposals in the invitation to the seminar on tariff-setting

Responses to the HMI high-level recommendations:

1. A review of the 2004 decision by the Commission to re-introduce collective bargaining under conditions that will be permissible under the Competition Act. We recognise that sharing of certain information would not only enhance the tariff determination process, but is also essential if we are to move from price only contracts to true risk-sharing models. Examples

of relevant information that should be shared by stakeholders during negotiations include utilisation, quality, coding, inflation and product cost data and/or statistics.

COLLECTIVE BARGAINING

SAMA would be in favour of the reintroduction of a collective bargaining model and some mutually agreed bargaining chamber to set the rules of engagement, governance procedures and eventually to determine recommended tariffs.

SAMA also believes that setting of hard tariffs for the whole industry will not be the solution. Business models, practice and input costs and multiple other factors at play in the diverse private sector practitioners grouping will simply not allow for this.

SAMA supports this process as one of benchmarking of tariffs and not as “tariff determination”. We believe that tariffs set should serve as a guide to practitioners, but that they should still be free to set and negotiate their own tariffs.

INFORMATION -ASYMMETRY

We caution the HMI to bear in mind that most of the collected information from medical scheme claims relating to utilisation, coding, inflation and cost information is kept within the medical schemes and medical scheme administrator environments.

While small pockets of physicians and societies have begun keeping their own records, most doctors have to accept aggregate data presented by the medical schemes – this is often suspect and not accepted as “truth” for various underlying mistrust issues.

This is a challenge for transparency and negotiating as it is often very challenging to obtain this information from medical schemes, unless in the format in which they choose to present it.

In addition, practice costs do vary throughout the country and it is unlikely that a single set tariff will address and cover the costs of all practice models.

SAMA PRACTITIONER PRACTICE COST STUDIES

SAMA is currently busy with a national practice cost studies (PCS) on General Practitioners and Specialists in private practice on behalf of the organisation and its members. The purpose of the

PCS is to conduct and publish a study into the actual costs associated with the running of a private medical practice in 2017.

SAMA's involvement in the PCS is limited to that of a funder – the entire PCS is conducted independently of SAMA, its board, its member committees, its members and/or any staff employed by SAMA.

The crux of the PCS is that it is conducted by independent third parties. The segregation of the PCS function from SAMA ensures that the results are free from interests within certain specialities or groups and provides for fair representation of research results.

The results of the PCS will be used to establish the health of private medical practices in South Africa and whether it can be expected that our private medical doctors will be able to operate sustainably in the future without intervention.

We believe that 60 – 70 % of practice costs are fixed costs, which may vary and which need to be factored in to tariff determination.

2. The tariff bargaining process should be hosted by **a regulator**, an organisation that is sufficiently independent from day-to-day control by either the NDOH or the private health sector. Key elements under consideration include:

i. The organisation to ultimately report to the Minister of Health as the custodian of health policy.

SAMA would be in favour of this. However price determination should not be undertaken blind of the costs facing practitioners and we believe, that like the pharmaceutical industry Single Exit pricing, practitioners should still be in the position to largely determine the tariffs that they are permitted to bill.

We also feel that once there is price regulation, quality measurement should be mandatory.

In South Africa, we are faced with an ongoing drain of practitioners to other countries. The private sector represents an avenue for keeping doctors in the country, provided they can make a decent living. Thus any price determination need to take into consideration to ensure ongoing availability of services, access and quality and the availability of the professionals.

Where practitioners can earn better in other countries, we unfortunately face the risk that they will move there to work.

There must also have mandatory annual reviews of the tariffs, and the inflation of the fees must ensure that skills are retained in the country. The agreement should resemble the 3-year wage sectoral agreements in the country, with the percentage increases agreed to at the tri-annual negotiations. The miniscule inflation –linked increases awarded to especially GP's in the private sector by medical schemes have demoralised the backbone of the primary health sector in the country. The incomes of the GP have lagged behind in comparison to that of state employed medical officers of similar training and experience.

The concept of fair living wage should be the basis of negotiation as doctors are workers too. Thus far, due to the failure of the state to revise the 2004 decision and the 2009 NHRPL, GP's have left the industry and many have filed for bankruptcy. The unintended consequence of the inability of GP's to earn a decent living wage will soon be evident in the decrease in number of students retained in the country post-qualification. (SA Study exists alluding to this)

One suggestion received is that GP's should be allowed to form regional trusts from whom government can procure services. The trusts could be semi-independent and self –running, but to retain their contracting status they should be independently audited. GP Trusts should be enabled to negotiate with government for the supply of primary healthcare services from their rooms. This will increase the prospects of general practitioners in the country by increasing practice sustainability. (UK System)

ii. The governing body, appointed by the Minister after a public nomination process, should have powers to appoint its accounting officer and, through appropriate delegations, other senior staff members.

SAMA is in agreement with this proposed process.

iii. We have a preference for a full-time, professional, multidisciplinary staff complement instead of stakeholder representatives who only meet during "tariff season".

SAMA is in agreement with this as part of the proposed process, providing running costs can be kept to a minimum; to prevent "high costs" with the aim to reduce overall costs, but with the eroding of funds available for patient care.

We view the Medicines pricing Committee as a structure that has managed, without full-time appointments, to make some great strides in medicines pricing regulation in the country. This

was off the back of a National medicines Policy and substantive regulatory additions and changes to enable the functioning of this committee. The committee is not full time and meets once a month.

We propose the formation of a pricing panel with representatives from healthcare industry specialists and little government control. The panellists should serve on a rotational basis each panelists serving up to 3 years, to avoid them being 'captured'. (The Department of Health has long had such a pricing panel in its Annual performance plans – but such as structure has failed to materialize.)

Stakeholder representatives nominated by the profession every 2-3 years are critical. The State may also appoint government representative to the panel/ committee.

We are concerned about the balance of power and the potential for monopsony – thus the tariff determination should be completely separated the influence of purchasers – who we believe exercise undue power in the market at the moment.

iv. In addition to working with industry to manage the tariff bargaining process, the organisation would be responsible **for developing and** maintaining equitable coding systems, which will be updated as necessary and standardised across the sector. It is imperative that coding systems facilitate public sector purchasing of private sector services and vice versa.

SAMA strongly believes that coding must remain the intellectual pursuit of clinical professionals and clinical coding experts. This is the worldwide standard for this very technical area.

Retaining clinical coding in the clinical space adds trustworthiness and acceptability for practising professionals. It can also be used as a peer review tool where disputes arise regarding on healthcare quality issues.

Clinical coding should also form an integral part of clinical governance structures and support frameworks for clinical practice guidelines and acceptable protocols.

It will also assist in NHI negotiations between the public and private sectors. The National Health Insurance does not yet have a clinical coding system to support the NHI proposals

v. The organisation to be funded by a combination of tax and (industry) fees or levies.

Users of private sector health and taxpayers are not a synonymous group. Many taxpayers may still use the public sector and should not be asked to fund a body serving the private sector. We

also do not believe that National Treasury would agree to let this body draw from the fiscus, which is already under tremendous pressure, funding initiatives in the public sector.

The NHI processes will also be looking towards tariff determination – but this is unlikely to involve a separate body, as it would fall under the proposed NHIF structures.

Industry levies on medical schemes and administrators may be most practical – given that presumably that the intention of tariff determinations will be to reduce costs overall, which is likely to benefit schemes and their members financially.

3. At this point, we do not have a firm view whether this body should serve only the purposes listed above or should also have a role in collation and analysis of quality data, practice profiling, etc. Comments whether all these functions should be housed in a standalone entity or even be integrated into an existing organisation are welcome.

As stated above, medical schemes and administrators seldom provide trustworthy data to the industry – This is largely because it consists only of claims data with very little insight into clinical and outcomes issues.

Regrettably we consider the Council for Medical Schemes, which might have the potential to serve to examine and advise on tariffs, has been unduly influenced by the groups they seek to regulate, because of the complexities of issues and the information-asymmetry problem. SAMA experiences how Medical Schemes and administrators find creative ways of stalling important improvement processes proposed by the CMS, and (once again because of information-asymmetry), find ways to ensure that changes implemented are to their advantage.

Quality measurement is core to fair pricing, and fair, well-informed practice profiling with clinical professional involvement in the selection of indicators and standards is also important. As the HMI is also proposing the setting up of a quality/ outcomes measurement body – perhaps this could also serve a tariff determination function in the future.

4. In all the countries where central, multilateral negotiation takes place, the establishment of a bargaining chamber or a semi-autonomous pricing authority is central to successful

price determination processes. These bodies are tasked with coordinating the bargaining process and determining the final and acceptable tariff increase for the year.

SAMA would be in support of a bargaining chamber, providing the imbalances in power and information asymmetry currently in the system can be addressed.

5. Internationally, countries regulate prices either through setting billing prices or compulsory maximum reimbursement levels. Price may not always be equivalent with the reimbursement level, but regulation of one or both may exist. These prices and reimbursement levels are usually arrived at through centrally administered pricing processes, or derived through multilateral negotiation processes. For the majority of OECD countries cited in the NDOH submission, prices arrived at are binding for provider billing, while in some countries providers are permitted to exceed the regulated price.[8]

8 NDOH: Submission to Competition Inquiry Panel, paragraph 205

6. In all the countries where central, multilateral negotiation takes place, the establishment of a bargaining chamber or a semi-autonomous pricing authority is central to successful price determination processes. These bodies are tasked with coordinating the bargaining process and determining the final and acceptable tariff increase for the year.

SAMA is in favour of tariffs forming a benchmark and not an absolute regulated quantity. If providers are entitled to set their own tariffs, however, balance billing is a real possibility.
If this is not going to be acceptable to the HMI then it is imperative that tariffs which are set and negotiated adequately incorporate value and cost elements.

While doctors and hospitals may be recognised as entities operating in a market, some countries have established legislationwhich authorises collective negotiations between providers and purchasers to set prices to help meet public policy objectives.
In France, the Social Security Code allows for negotiations between the medical associations and the National Union of Health Funds (Union nationale des caissesd'assurance maladie).
This is also the case in Switzerland, where the Federal Health Act allows for negotiations between medical associations and insurers' associations.
In addition, the Swiss Cartel Act explicitly excludes from its application the "statutory provisions that do not allow for competition in a market for certain goods or services." In particular, these

provisions take precedence over the Cartel Act and include the provisions that "establish an official market or price system."

7. The HMI is of the view that collective bargaining alone, even under acceptable conditions from a competition perspective, may not yield the desired cost-effective, quality outcomes. This may largely be attributed to other acknowledged features of the healthcare market, including information asymmetry between funder and scheme member, funder and service provider, patient and practitioner; moral hazard; supplier induced demand and unique relationships between practitioners and health establishments.

8. As a result of these factors, we are of the view that price regulation bears consideration. We would like to explore this subject within the context of a multilateral bargaining environment, which is likely to form part of our proposals while price only contracts are in place.

The asymmetry concerns remain – both in terms of access to information and bargaining power. Our doctors suffer currently from a "take it or leave it" attitude of medical schemes, which have effectively become price-setters in network and designated provider negotiations. If it is possible that a multilateral negotiating environment can assist in solving this problem – SAMA would be in support of it.

9. In making comments on price regulation, stakeholders should consider the following:

Whether multilateral negotiations on their own would be sufficient to render the private sector sustainable (from a tariff determination perspective) in a price only environment;

Fair price determination should take into consideration actual costs of providing health care. Any arbitrary, non-transparent price determination will results in demise of health care.

There needs to be power balance between doctors, hospitals, funders and Government in such negotiations. We need to be careful of Monopsony in view of upcoming NHI.

This process will require strong negotiators, data mining to provide the basis of negotiation. Providers are generally on the back-foot when it comes to such information.

We believe this will require acceptability of clinical associations to collect, access and analyse the data needed and the employ or contracting of personnel that can do the private sector negotiating on behalf of their members – both specialists and the general practitioner; without undermining the rights of either group.

10. In an environment where prices are regulated, should the final tariff guidelines be determined by the independent organisation (referred to above) after consultation **with sector stakeholders; the multilateral bargaining forum representative of stakeholders; the NDOH or other entity.**

Multilateral bargaining forum representatives, as this will dilute the schemes power. But we recognize that the provider grouping in this instance is not a homogenous one.

11. We are also mindful that a case can be made for certain categories of providers to be allowed to negotiate directly with funders on a bilateral basis. The likely providers in this regard could be those that are corporatized, generally have high capital costs and are significantly fewer in number than professionals in solo practice. These include facilities, pathologists and radiologists. Comments for or against this approach, with reasons, is encouraged.

From General practitioner perspective, corporatisation of GP practices is more likely to be in the urban areas. We caution the HMI that any negotiations should not result in disadvantaging rural practitioners who are likely to be solo, yet serve the deserving populations. In actual fact there needs to be an increased weighting for rural doctors as they are likely to do more procedures than urban counterparts.

12. We are firmly of the view that, under any scenario, service providers should have the freedom to charge lower tariffs than those recommended through any regulatory mechanism. However, the government regulatory bodies may not enforce the lower tariffs to the detriment of the industry. The bargaining processes should be observed as in the public health sector employee negotiations.

This provided that price setting is transparent and fair and take into consideration cost of providing the service. A price that is too low may result in demise of private health care as is the case with general practice.

Quality of health care may also be compromised due to underservicing under pressure of low fees.

There are too many medical scheme options with too little membership to give adequate cross-subsidization through contributions. Especially GP's are subsidizing these plans by being forced to accept below-par consultation fees; while practice costs increase above inflation and professional fees decline rapidly.

13. Final tariffs should be published widely for easy access by consumers, service providers and all stakeholders.

Whenever these fees are published for the information of the public, it should also have a rider that clearly explains how the tariffs were derived and what the threshold (ceiling) tariff amount is (above the benchmark tariff) – otherwise the public will cause administrative costs by also complaining about tariffs charged appropriately above the benchmark. This will be part of transparency

Stakeholders are encouraged to, as far as possible, make consolidated proposals on the various possible tariff determination models. The high-level principles identified