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Competition Commission of South Africa

The Health Market Inquiry Panel

Via email: paulinam@compcom.co.za

7 September 2018

Dear Sir / Madam

COMMENTARY ON THE HEALTH MARKET INQUIRY PROVISIONAL FINDINGS AND RECOMMENDATIONS REPORT ("Report")

This submission is made on behalf of MediKredit Integrated Healthcare Solutions (Pty) Ltd and its wholly owned subsidiary Performance Health (Pty) Ltd, an accredited managed care organisation providing pharmaceutical benefit management services ("MediKredit"). The MediKredit business was established as far back as 1941 and it is also the proprietor of the NAPPI coding system. MediKredit values the opportunity to comment on the recommendations made by the Health Market Inquiry Panel ("**Panel**").

Please note that this commentary only pertains to certain aspects of the Report. Matters not addressed or commented on must not be construed as either approval or disapproval of such matters. The comments below relate to the matters addressed in the Report that MediKredit found most pertinent. Comments have been made with reference to the relevant paragraph numbers as indicated in the Report.

1 <u>Ad Paragraph 27</u> – ***We find no evidence that schemes demand information on the costs saved by administrators related to, for example, managed care or fraud control and whether the related savings are passed on to scheme members:***

1.1 This statement does not apply in all cases.

1.2 MediKredit provides information on cost savings to all the schemes that it services. The cost savings achieved by MediKredit's services are reflected in the quarterly reports provided to the Boards of Trustees. This provides these Boards with transparency in terms of the savings achieved by its services, which can then be compared to the cost of the services.

1.3 In addition, as part of the accreditation renewal process for managed care organisations, which takes place every two years, the Council for Medical Schemes ("CMS") requires each managed care organisation ("MCO") to comply with a set of specific standards. Standard 3.2.3.1 is a structured Cost/Benefit Analysis where the MCO is required by the CMS to demonstrate in a Value-Added Template how it achieves value through providing access to care, delivering measurable cost savings and ensuring quality of care.

1.4 Please refer to the CMS' website for an example of the standard Value-Added Template: https://www.medicalschemes.com/files/Managed%20Care%20Organisations/MHCSelfEvaluatingChecklist2011.pdf

1.5 An example of the most recent Cost Benefit Analysis (Value Added Template) as completed by Performance Health (Pty) Ltd is also available on request subject to the confidentiality thereof.

2 Ad Paragraph 29 – ***Therefore, the panel recommends measures to strengthen governance to ensure that schemes place greater pressure on administrators to deliver value to members, that members place greater pressure on schemes to improve value for money, and measures that enable the regulator (the CMS) to exercise more effective oversight over funders:***

2.1 MediKredit disagrees that its medical scheme clients demand no accountability from it to manage healthcare costs and demonstrate value. MediKredit experiences significant (and appropriate) pressure from all our scheme clients to mitigate claims inflation.

2.2 The vigorous CMS accreditation process also requires MCOs to demonstrate how they achieve value to members. Please also refer to our comments in paragraph 1 above.

2.3 In addition, due to the highly regulated environment, various reports have to be submitted to the CMS. Further overview is supported by on-site CMS evaluations, routine CMS compliance inspections, as well as audits by external auditors; both on the scheme as well as the MCO and its systems, processes and procedures. All these governance measures have value to the schemes and its members as a key focus area.

3 **Ad paragraph 30.1** - ***multidisciplinary team-based care****:*

3.1 Multidisciplinary team-based care has been hindered to a large extent by the HPCSA's Ethical Rules which has prevented several multidisciplinary team arrangements being implemented, as well as the lack of tariff codes to enable reimbursement of claims for healthcare provider collaboration across various disciplines.

3.2 Currently in South Africa there are over 40 different coding structures used by healthcare practitioners to invoice patients/medical schemes/medical insurance for healthcare services. This means that medical, dental, hospital, auxiliary and allied practices have different codes for the same or similar services. The Board of Healthcare Funders ("BHF"), which manages the practice numbers for all healthcare practitioners, allow for group practices to be registered, however there is no combined coding structure that allows for the billing of a multi-disciplinary consultation.

3.3 For General Practitioners, who bill from the Medical Practitioners coding structure, there are 4 main tariff codes to bill for a consultation in the rooms namely, 0190, 0191, 0192 and 0193. All these codes have the same description and only differ as regards the length of the consultation. There is also a tariff code 0130 that allows for a telephonic consultation, however the coding structure does not yet cater for the coding of an internet/skype consultation. Furthermore, where multi-disciplines are involved in the same consultation, the coding structures currently only allow that each discipline bills a full consultation from their relevant coding structure. This is not optimal since it requires each discipline to bill separately which not only increases the healthcare cost but also makes it difficult to split the fees.

3.4 Since the last Reference Price List was published in 2009, each association has been mandated by their own members to publish updates to their own coding structure, but unfortunately none of

the updates have included multi-disciplinary tariff codes. Even though this is encouraged by the act amendments proposed in preparation for NHI, it is imperative that coding be considered if these services are to be paid/reimbursed by medical schemes or insurers.

4 <u>Ad Paragraph 56.6</u> - *The lack of consistent and standardised reporting of health outcomes:*

4.1 The fact that there is a lack of consistent and standardised reporting on outcomes can, in part, be attributed to the fact that there is no standard set of health outcomes that are agreed upon in the industry and that furthermore the methodology of calculating such outcomes is not available or standardised.

4.2 This highlights the need for a standard set of health outcomes (or quality care outcomes) that is under the control of an independent Outcomes Authority which will develop the outcomes to be measured and the methodology for calculating such outcomes.

5 <u>Ad Paragraph 56.8</u> - *The failure to implement evidence-based guidelines and treatment protocols:*

5.1 Although the Panel deems that there is a lack of effort by providers of care (supply side) to implement evidence-based guidelines and treatment protocols, managed care organisations such as ourselves place significant importance on the implementation of these guidelines and treatment protocols. In this regard, some MCOs such as Performance Health (Pty) Ltd drive the application of evidence-based guidelines through pre-authorisation and case management activities which engage the providers of care.

6 <u>Ad Paragraph 56.9</u> - *The lack of an effective framework for health resource planning and economic value assessments of, for example, new healthcare technology:*

6.1 It is not true that there is a lack of an effective framework to perform economic assessments of new healthcare technology. An effective framework is in place for pharmacoeconomic evaluations.

6.2 In this regard the Department of Health, in terms of Regulation 14 (5) of the Medicines and Related Substances Act, publishes Guidelines for Pharmacoeconomic Evaluations in the

Government Gazette. This framework for assessing new technologies is used in the industry to assess the economic value of high cost medicines such as the new biologicals.

7 <u>Ad Paragraph 105.4</u> - *Standardising coding systems to facilitate the monitoring, analysis and publication of expenditure trends and health outcomes:*

7.1 MediKredit fully supports this recommendation. Please also see our further comments under paragraph 10 in this regard.

8 <u>Ad Paragraphs 110 – 111</u> - *Regulated pricing:*

8.1 Of the two tariff setting mechanisms proposed by the Panel, the regulated option of tariffs being set by the SSRH after input from a multilateral forum is preferred and more pragmatic. The alternate multilateral price setting mechanism where stakeholders conduct tariff negotiations under a framework and with conditions determined by the SSRH, may be open to abuse as a result of the market dominance of the service providers and facilities.

8.2 MediKredit welcomes the fact that tariffs for PMBs will be binding and that the tariffs for non-PMBs will have the status of reference tariffs, which may only be exceeded if the patient's informed consent has been obtained, or as a result of negotiations between service providers and funders.

8.3 More detail is required in respect to how the arbitration process will work.

8.4 Medicines have been subject to regulated pricing for several years: Pharmaceuticals are regulated by the Single Exit Price (SEP) which is determined under Regulation 8(1) of the Medicines and Related Substances Act which relates to transparent pricing. The SEP is a fixed price at which a specific pharmaceutical product must be sold. In addition, dispensing fees (pharmacies and dispensing doctors) are regulated by Section 22G of the Medicines and Related Substances Act. The dispensing fees are published from time to time in the Government Gazette and are a maximum fee, not a fixed fee.

8.5 Considering the above, it is proposed that whichever system is decided upon to regulate pricing in the healthcare industry that this single system should apply to all healthcare providers, including medicine providers (pharmaceuticals and dispensing fees). To have two different systems regulating pricing in the healthcare industry could be considered unfair, if not discriminatory.

8.6 We are of the opinion that the Regulator should be responsible for setting fee-for-service tariffs (Option 1), with meaningful engagement from stakeholders.

9 <u>Ad Paragraphs 137 – 140</u> - *Establishment of an independent supply-side regulator for healthcare (SSRH):*

9.1 MediKredit supports the establishment of a SSRH and the proposed structure and urge that this be set up as soon as possible, preferably sooner than the suggested five years from date of publication of the final Inquiry report (Paragraph 138).

10 <u>Ad Paragraphs 147 – 151</u>: *Coding systems*

10.1 **Current Coding Systems for Pharmaceutical, Surgical and Consumable Healthcare Products in South Africa**

10.1.1 In the South African <u>public healthcare sector</u>, multiple coding systems are used for healthcare products, namely, the National Stock Number (NSN) for procurement, Regional Stock Codes for supply and the Uniform Patient Fee Schedule (UPFS) for billing. The National Department of Health (NDOH) has communicated that it was considering implementing the GTIN-14 Datamatrix barcode requirement in the special requirements and conditions of contract for pharmaceutical products.

10.1.2 In the South African <u>private healthcare sector</u>, various internal identification codes are used for procurement, supply and distribution such as manufacturer or supplier catalogue numbers and various barcoding systems including EAN-13 and the GTIN-14 Datamatrix barcodes. For billing and patient administration, the NAPPI code has been entrenched as the industry standard for almost two decades, which enables healthcare

providers to claim from medical schemes and other funders of healthcare. The NAPPI code is also used in other areas of the healthcare value chain for electronic transfer of information such as procurement and supply, and reporting and analysis.

10.2 **The NAPPI Coding System**

10.2.1 NAPPI (National Pharmaceutical Product Interface) is a globally unique national coding system, for pharmaceutical, surgical and consumable healthcare products in South Africa.

10.2.2 A NAPPI code is a unique identifier for a given ethical, surgical or consumable healthcare product which enables electronic transfer of information throughout the healthcare delivery chain.

10.2.3 NAPPI codes enable healthcare providers to claim from medical schemes and other funders of healthcare for the reimbursement of products via a unique, healthcare funder-recognised code. NAPPI has also been voluntarily adopted as a national electronic standard on behalf of the South African private healthcare industry for almost two decades.

10.2.4 MediKredit, as custodians of the NAPPI Product File, has been publishing the allocated NAPPI codes in the public domain since inception free-of-charge.

10.2.5 Application for a NAPPI code is a voluntary process that is initiated by the manufacturer / supplier.

10.2.6 MediKredit allocates NAPPI codes in accordance with the NAPPI Allocation Policy as governed by the NAPPI Advisory Board (NAB) and applicable legislation to ensure NAPPI meets the needs of all of its stakeholders.

10.2.7 NAB constitutes of industry stakeholders such as medical schemes and administrators, the South African Medical Association, the South African Dental Association, the Board

of Healthcare Funders, private hospital groups and the South African Medical Devices Industry Association, amongst others.

10.2.8 There are currently over 320,000 active NAPPI codes on the NAPPI file. This is made up of approximately 8,000 active NAPPI codes for category A medicines, about 14,000 active NAPPI codes for complementary medicines and about 300,000 active NAPPI codes for medical devices, appliances and consumable healthcare products.

10.3 **No single code to meet all requirements**

10.3.1 Whilst we agree with the recommendation that coding systems across the sector be standardised, it is important to appreciate that it may be required that different coding standards would be required for different functions.

10.3.2 There is currently no available coding system that is able to cater for procurement, supply and distribution as well as billing and patient administration. The reason is that it may not be possible to use the same coding standard since certain attributes and standards may be different for these two purposes. For example, for procurement, supply and distribution of paediatric syrups, a unit of measure of unit (1 bottle) will be appropriate since it would not be distributed along the supply chain in a quantity smaller than 1 bottle. Whereas for patient administration and billing, the smallest pack size cannot be 1 bottle since it is common to make mixtures of more than 1 paediatric syrup hence an appropriate unit of measure would be milliliter enabling administration and billing for a specific volume of medicine from a bottle.

10.3.3 There is no off-the-shelf coding solution available for patient administration and billing since the requirements for this function is highly complex and varying amongst the stakeholders in this environment. It is therefore critical that the coding system be developed to meet the requirements of all of its users.

10.3.4 The NAPPI coding system would be an ideal coding standard across the entire healthcare sector in South Africa for billing, patient administration and other

applications requiring electronic transmission of healthcare information for pharmaceutical, surgical and consumable healthcare products since it is already entrenched within the South African private healthcare sector for the last two decades and has been honed and refined during this time to successfully meet all of the requirements of its users.

10.3.5 The NAPPI coding system could easily be expanded to meet the needs across both the private and public healthcare sectors.

10.4 **Interoperability**

10.4.1 Since multiple coding systems may be required within the healthcare value chain as explained above, it is critical to establish interoperability amongst these coding systems to ensure meaningful exchange of information across the entire healthcare system.

10.4.2 The NAPPI coding system has been designed to maintain differential healthcare information across multiple countries and sectors such as regulatory information, pack size, pricing, etc. This feature would be particularly useful in South Africa where pack sizes and pricing for the exact same product from the same manufacturer is very often different across the private and public healthcare sectors.

10.4.3 The NAPPI code also already caters for interoperability with the public sector National Stock Number (NSN), various manufacturer and supplier catalogue numbers, the EAN-13 and the GTIN-14 Datamatrix barcodes.

10.4.4 In addition, the NAPPI coding system is currently being enhanced to cater for interoperability with the Global Medical Device Nomenclature (GMDN) codes which has been endorsed by the Global Harmonisation Task Force (GHFT) as the preferred nomenclature system for regulatory purposes for medical devices and is as a result also a requirement by the South African Health Products Regulatory Authority (SAHPRA) for the application for licensing for medical device manufacturers, distributors and wholesalers.

10.4.5 It is also important to note that not only does the NAPPI code cater for interoperability with the GTIN-14 Datamatrix barcode, the GTIN-14 Datamatrix barcode also caters for interoperability with the NAPPI code since it already provides for the NAPPI code in its 900 field reference database for certain users of the GTIN-14 Datamatrix barcode in South Africa.

10.4.6 The NDOH's intended application of the GTIN-14 Datamatrix barcode, as documented in Government Gazette No 41114, is:

10.4.6.1 Enabling end-to-end data visibility;

10.4.6.2 Identifying and implementing supply chain efficiencies;

10.4.6.3 Ensuring supply chain security; and

10.4.6.4 Improving patient safety.

10.4.7 It is important to note that this intended application does not include billing and rightly so since it is not suitable for this purpose.

10.4.8 The NAPPI code is also currently a requirement by the Pharmaceutical Economic Evaluation Unit of the NDOH as part of the Single Exit Price Adjustment application process and it is also published on the Database of Medicine Prices as part of the product information on the Medicine Price Registry.

10.4.9 The NAPPI code therefore has not only been entrenched in the South African private healthcare sector for almost two decades but also has established interoperability with almost all coding systems used across both the public and private sectors hence it would be the ideal solution to enable a single coding system to operate across the private and public healthcare sectors in South Africa and furthermore would allow for a seamless transition into a single national healthcare system.

10.5 **Quality and Accuracy**

10.5.1 To ensure integrated sustainable reporting on pharmaceutical, surgical and consumable healthcare cost and utilisation, it is critical that the underlying product information is accurate and up-to-date. The NAPPI coding system has been successful in fulfilling this

requirement due to the all of the policies, procedures and systems that have been specifically designed to ensure the highest degree of quality and accuracy.

10.5.2 All NAPPI policies and procedures are governed by an entrenched formal quality management system that is ISO 9001:2015 certified to ensure the highest degree of quality.

10.5.3 The NAPPI codes are allocated and maintained by a highly skilled multi-disciplinary team in accordance with the policies governed by the NAB which is represented by all stakeholders and users of the system. There is ongoing maintenance of the system to ensure it is always up-to-date.

10.5.4 There is an in-house developed IT system for the allocation and maintenance of the NAPPI codes. The IT system comprises a user interface, programs and a database that is used to create NAPPI codes and maintain all NAPPI information.

10.5.5 The IT system is very sophisticated and makes use of masterfiles to allocate and maintain NAPPI attributes to ensure accuracy and consistency of data. The system also makes use of clinical overcoding that allows attributes to be automatically allocated to products that have the same ingredient or combination of ingredients, strength and dosage form which further enhances the accuracy and consistency of data.

10.5.6 There is a separate department within MediKredit responsible for the quality control of all NAPPI codes allocated and all updates to the NAPPI code. New NAPPI codes and changes to NAPPI codes will only be implemented once it has successfully passed the quality control process.

10.5.7 In addition, to ensure the NAPPI file has the most accurate and updated product and price information, MediKredit has the following processes in place:

10.5.7.1 Direct communication from the National Department of Health for product launches, price updates and product discontinuations;

10.5.7.2 Weekly product and price comparisons with Netcare, Life Healthcare, Mediclinic and NHN hospital groups;

10.5.7.3 Weekly price comparison with the largest pharmacy practice management software vendor in South Africa;

10.5.7.4 Direct relationship management with manufacturers and suppliers;

10.5.7.5 Regular training across the country to manufacturers and suppliers.

10.6 MediKredit considers the setting up of a central, standardised coding system under the control of an independent body, an urgent priority given the current situation where codes are being manipulated, unbundled and used inappropriately and inconsistently – all of which contributes to ever-rising healthcare costs.

10.7 However, whilst MediKredit agrees with the recommendation for the SSRH to outsource certain parts of its work on coding systems to independent experts, we do not necessarily agree that this should be academics per se. The criteria for appointing independent experts should include considerable prior experience of working with codes and coding within the private sector funding environment in South Africa.

10.8 This highly specialized area requires extensive practical experience in the successful implementation and maintenance of coding systems as well as a successful proven track record of the application of the coding system within the healthcare system. In this regard, the NAPPI coding system is an example of a system that has been tried and tested in the private healthcare sector and has successfully met all of the requirements of this sector for almost two decades.

10.9 The success of the NAPPI coding system is also attributable to the NAPPI Advisory Board, which consists of various stakeholders across the industry, who give practical input on specific requirements of the industry.

10.10 Whilst the recommendation of a central, standardised coding system under the control of an independent body is supported, a mechanism will be required to ensure that input from various stakeholders are considered and implemented where appropriate. For a coding system to work, it

needs to be robust and policy decisions need to be made quickly to ensure that appropriate requirements of the industry are met.

10.11 **Willingness to Engage**

10.11.1 MediKredit does agree with the Health Market Inquiry recommendation that coding is a highly specialized area and that the SSRH should have the mandate to outsource certain parts of its work to independent experts however do not agree that this expertise resides within academia.

10.11.2 This highly specialized area requires extensive practical experience in the successful implementation and maintenance of coding systems as well as a successful proven track record of the application of the coding system within the healthcare system. In this regard, the NAPPI coding system has been tried and tested in the private healthcare sector and has successfully met all of the requirements of this sector for almost two decades.

10.11.3 MediKredit hereby reiterates its sincere willingness to engage with the NDOH to find the most appropriate way on how the NAPPI coding system can be made available to the public healthcare sector in order to meet the NDOH requirements and fulfill the need for a single coding system across the public and private healthcare sector.

11 Conclusion

MediKredit wishes to commend the Panel on the execution of this mammoth task in a succinct manner. The adoption of the appropriate recommendations will greatly improve competition, innovation and accessibility in the sector and lead to reduced costs, provided that the recommendations are implemented properly and timeously.

Yours faithfully

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KRISH PATHER

Director: Performance Health

Chairman: NAPPI Advisory Board