SUBMISSION TO THE HEALTH MARKET INQUIRY 25 FEBRUARY

Introduction

1. The Dental Professionals Association (DPA), is a representative association of predominantly black dentists and dental specialists in South Africa.
2. The DPA is incorporated as a “not-for-profit” company under section 21 of the Companies Act 61 of 1973. It is governed by the board of directors, who are also dentists and members, and the executive committee.
3. Historically, black people were excluded by the apartheid legislation from studying dentistry and it is thus the case that black dentists are still few, in relative terms, in South Africa
4. The membership of the DPA currently stands at about 400 dentists. The majority of our members work in the private sector on a full time basis, others work in the public sector on a full time basis, and some work in both the private and public sectors on a part-time basis.
5. The rapid increase in the numbers of black dentists has increased (we believe) access to oral and dental services to previously under-served areas that include townships, rural areas and even squatter camps. It is our estimates that there are about 800 black dentists in South Africa.
6. **The predominant form of payment for dental services is through medical scheme reimbursements, particularly for preventative, restorative and complex dental treatments (dentures, endodontics, periodontics and orthodontics). Cash payments for dental services relate mainly, but not exclusively, to pain and sepsis related treatment procedures (dental extractions).**
7. It is common knowledge that 83 percent (83%) of the population depend on the public services for their healthcare needs and only 17 percent (17%) are served by private healthcare services. Access to private healthcare is made possible mainly through pre-payments to medical schemes. However, given the high levels of inequality and unemployment, it is our submission that a smaller proportion of the population (township and rural) which is serviced by our members have medical scheme cover.
8. Access to medical scheme cover is generally a preserve of the gainfully employed. In the context of the townships and peri-urban areas, this refers to the black middle class, especially public servants (teachers, nurses, administrators) and their dependents.
9. It is also common cause that household debt levels of the middle class are also high which results in less disposable funds which could be available for healthcare services. Dental diseases, unlike other diseases, are not life threatening and people are likely to defer visits to the dentists in the face of other competing demands on the household income.
10. The shortage of office infrastructure and unreliability of water and electricity supplies to the townships, coupled with other social problems, including violent crime, makes dental practice in the township to be more challenging.
11. People who live in the townships generally commute to work in the towns and cities on a daily basis with attendant decline in day-time population levels in the townships. This phenomenon has resulted in dentists establishing dental clinics in the city centers to cater to the demands of the market.

Market overview of private dental provision

12. The publicly available records about the position of dentistry in the context of the private healthcare market are derived from the annual reports of the Council for Medical schemes (CMS) which can be downloaded from its website. The earliest downloadable report dates back to 1993[1]. For the year under review, the share of payments to dentists (including dental specialists) accounted for 9 percent (9%) of the Gross Contribution Income (GCI) of medical schemes.
13. In the annual report of 2000, the payments to dentists had declined to about 4 percent (4%) of the GCI[2].
14. In the annual report of 2010, the payments to dentists had declined further to about 3 percent (3%) of the GCI[3].
15. In the annual report of 2015, the payments to dentists has declined to 1,8 percent (1.8%) of the GCI[4].
16. In general, the rate of tariff increases to dentists, over the period, has been increasing at less than the rate of inflation. Dentists have become worse off over time.
17. The above statistics are a consolidation of the figures across all medical schemes. It is the average of all benefit options, starting with the low-cost options with limited benefits to the high-cost options with comprehensive benefits. It is our submission that most patients who receive services from members of the DPA are more likely to belong to the low cost and standard options of their medical schemes. In addition, the schemes are more likely to cater for the government-related employees. Such schemes will include, but not limited to, Gems (national and provincial government employees), Polmed (employees of the South African Police Services, Bonitas (employees of state-owned entities) and Samwumed (local government employees).
18. The real impact of funding for dental services should ideally be assessed at scheme and benefit option level. For instance, the overall applicable limit on the Gems Emerald option has decreased by 10 percent (10%) between 2015 and 2016, with consequences that will be devastating for both the patient and the provider.
19. Medical schemes are generally able to keep payments to dentists low through a variety of measures including collusion, monetary limits, and the so-called managed care protocols, such as, bureaucratic pre-authorizations, clinical rules and protocols, treatment exclusions. **The most devastating managed care strategy is the designated provider networks and they shall be dealt with in this presentation.**

The cost dynamics of a dental practice

20. The capital costs of establishing a dental practice are high given the cost of basic dental and radiology equipment which is invariably imported. The cost thereof has been increasing in the recent years due to the depreciating currency.

[1] CMS Annual Report 1993.
[2] CMS Annual report 2000.
[3] CMS Annual report 2010.
[4] CMS Annual report 2015.-

21. The cost labour is a significant item in the income statement of any dental practice given the professional nature of the dental staff, such as that of a dentist, oral hygienist, dental therapist and more recently, the dental assistant. The benchmark for the cost of labour is the equivalent remuneration in the public sector which is high due to the occupation specific dispensation (OSD) that is applicable to healthcare professionals. The auxillary staff such as the receptionist and accounts clerks is also important given customer care requirements and the bureaucratic processes related to complex medical scheme requirements.
22. The cost of dental materials which are also imported and are subject to currency movements add to the total costs of running dental practice.
23. Costs related to electricity, water, municipal rates and facility rentals are also significant.
24. Administration of medical claims, bookkeeping, telecommunications and filing of tax returns also add not insignificantly to the overall costs of a dental practice
25. The profitability of a dental practice depends on the ability to generate income that will more than cover the costs of running a dental practice and making provisions for tax.

The revenues of a dental practice

26. Revenues to a dental practice are mainly, if not exclusively, derived from reimbursements for the dental treatment provided to its patients.
27. Ideally, the dental professional should be able to establish tariffs of the dental practice given the input cost considerations and the required return on capital. Those practice that are not contracted to medical schemes, it is assumed, they are able to establish their tariffs in this manner.
28. Other practices that are contracted to medical scheme are able to establish their own tariffs and the shortfall from medical scheme tariffs is paid by the patient. This is called balanced billing.
29. However, most dental practices use medical scheme rates as the de-facto tariff for their services, irrespective of whether such tariffs cover the input costs or not. This is due to the competitive nature of the dental practice where the consumers are generally not willing or are unable to fund additional healthcare costs, over and above the payments that have been made to the medical schemes.
30. Previously, the medical schemes used to collectively set the tariffs that would be applicable across the industry. This process was however deemed by the Competition Commission to be anti-competitive and was set aside.
31. The department of health (DoH), the CMS and professional organization subsequently embarked on a process called the National Health Pricing List (NHRPL) to establish the appropriate tariffs, but the process was set aside by the North Gauteng High Court in 2010.
32. Currently, individual medical schemes set their tariffs. However, these tariffs bear no relationship to the actual costs of providing the services and are simply the 2006 RPL rates that have been adjusted for inflation. Most importantly, the tariffs are more or less similar across the medical schemes which is suggestive of price collusion.
33. Unfortunately, the tariffs that apply to dental procedures bear no resemblance to the actual costs of providing the service. Medical scheme tariffs are generally 100%-300% lower than the real cost of providing the service. Evidence is provided in annexure 1 which is

derived from the previous submission by the South African Dental Association (SADA) to the HMI in 2015.

34. According to the submission referred to above, the tariffs that were used in 2015 were still significantly less than NHRPL tariffs of 2009, despite there being no adjustment for inflation.
35. **Given the medical scheme tariffs, it is clear that providers do not have a choice but to institute balanced billing in order to run their practices profitably. Unfortunately, medical schemes give the impression to their members that their tariffs are fair and have been negotiated with the providers when the opposite is true. This results in tensions and disputes between the providers and patients when co-payments are introduced.**
36. Other medical schemes have sought to coerce providers into charging the medical scheme tariffs by excluding them from direct reimburse if they charge their practice specific tariffs. This invariably results in increased risk and bad debt for the provider and more often than not providers will either submit or resort to split billing which is illegal under the HPCSA ethical rules.
37. **Providers do not only have to deal with low medical scheme tariffs but are subjected to managed care protocols and pressure to contract to designated provider networks with even more damaging consequences.**

Managed care and designated provider networks

38. Managed care is defined by the Medical Scheme Act 131 of 1998, regulation 15, as: **"clinical and financial risk management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant healthcare services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes".**
39. The history of managed care in dentistry can be traced to introduction low cost low benefit options in the late 90's. The rationale for low cost options was to provide but affordable healthcare to people who would not afford the traditional medical scheme cover.
40. The people who bought into this type of cover ordinarily knew that it imposed significant limitations on the healthcare benefits that they would receive from whomever healthcare provider. For instance, patients knew that their dental benefits were only limited to basic dentistry and would not expect more.
41. However, the low cost options were posing a competitive threat to the traditional medical schemes and in reaction, the medical schemes introduced their low cost options. The administration of these low cost options was outsourced to the pioneering administrators of low medical schemes, such as Prime Cure and Care Cross, usually under capitated agreements.
42. The scene was thus set for other dental managed care companies to emerge and increasingly the dental benefits of medical schemes were outsourced to managed care companies.
43. To the extent that regulation 15 refers to evidence-based managed care, the experience of the dental profession is nothing other than a **non-tariff limitation of access to dental care for medical scheme members**. This is achieved through a cocktail of clinical rules and protocols, exclusions, limitations, pre-authorizations and time-based limitations.

44. It is a very complex and risky environment for the providers given that there are 83 medical schemes, each with several options and each option has its unique managed care protocols. This requires massive investments in dental benefits administration but even the most efficient practices are not immune from the bad debts that invariably arise.
45. Most concerning to the DPA is that what was previously regarded as low benefits (associated with low cost options) have migrated up to the traditional options and high cost options. **High cost options have thus become low benefit options**. This thus means that dental benefits across high cost options have been reduced drastically with the loss of dental benefits to the medical scheme members. Reference is made to annexure 2 (page 14) which shows the similarity in the different benefit options of Gems.
46. It is our submission that managed care companies derive a disproportionate benefit for the services that they are providing. **Put differently, healthcare rands are diverted away from health to non-healthcare expenditure.** Annexure 3 is a document dealing with the managed care contract between Bonitas and Denis and it shows the disproportionate benefits that accrue to Denis.
47. The elephant in the room is the extent to which medical scheme members are not aware of the severe limitations on their dental benefits. It thus becomes the responsibility of the dentists to explain the limitations to the patients.
48. It is a huge concern, from a competitive point of view that whereas there are 83 medical schemes and several hundred options, there are only two dominant dental managed care companies, namely Denis and DRC. **This has given rises to monopoly tendencies which is further driving down the tariffs and standardizing treatment protocols across the different options and different schemes.**
49. These managed care companies are aggressively coercing providers into designated networks. Given their monopoly position, opting not to join the network effectively means the provider is excluded from medical scheme reimbursements, with potentially disastrous consequences. This limits the choice of provider that is available to the patient and also access to quality healthcare is compromised.
50. **Through the designated provider networks the managed care companies are seeking to establish their position as the de-facto providers and funders of dental services in the country. This is an unprecedented development that was not foreseen by the drafters of the Medical Schemes Act.**

Revised Statement of Issues (RSOI)

51. The HMI, on 11 February 2016, issued a revised statement of issues (RSOI) which are intended to expand on the original terms of reference (TOR).
52. In respect of the original TOR, the DPA endorses the submission made by SADA to the HMI on 31 October 2014 and the subsequent points of clarity on 26 March 2016.
53. The submission of the DPA will thus focus on the RSOI and mainly on the issues that have an impact on the provision in general, but of dental services in particular.

Risk pooling failures

54. The fundamental weakness of the system of private healthcare is the embrace of the neo-liberal ideologies that healthcare is a private good which can be traded as a commodity in a free market.
55. Paragraph 43, of the RSOI document, is thus correct that insurance products in healthcare are unsustainable given that due the difficulties in estimating the probabilities of health events and the relative certainty that a certain group, for example the elderly, will require treatment for a variety of ailments.
56. In South Africa, the mere fact that 84 percent (84%) of the population are excluded from access to private healthcare points to a market failure of extreme proportions. The concentration of healthcare resources at the disposal of a few leads to a massive distortion within the healthcare value chains, limits access to healthcare and it increases inequality in society.
57. The above, notwithstanding, the risk pooling failures are at best a feature of particular medical scheme or particular benefit options within the medical scheme offering. For instance, the Gems Onyx options has consistently had a claims ratio greater than the GCI due the concentration of pensioner members within this option[5].
58. Other risk pooling failures are deliberate and self-inflicted (if not self-serving). For instance, 34,6 percent (34.6%) of medical schemes had benefit options that had fewer than 2500 members and 59.6 percent (59.6%) of these were loss making. This begs the question of why and in whose interest do these benefit options exist?
59. In respect of dental benefits, it is our submission that the risks relating to failures of risk pooling could easily be compensated by a focus on adequate diagnosis and treatment of dental diseases at an early age and a focus on prevention. This should reduce the need for expensive rehabilitation type treatment later in life.

Market price and cost distortions

60. The DPA is in agreement that there is a high degree of price distortions in the private health market, but we disagree that the distortions arise due to the pre-payment nature of health insurance or the absence of point-of-sale charges. The reason for pre-payment is precisely to cover healthcare costs when the need does arise and it will be fundamentally unfair to put the put the blame on the consumers of health services.
61. **The reasons for the price distortions can be ascribed to the fee-for service environment which has in-built incentives for over-servicing by the providers of healthcare. This is particularly true for monopoly providers such as private hospitals, pathology groups and pharmaceutical companies. The collusive practices between these providers and perverse incentives that are common in private healthcare.**
62. Cost distortions, particularly as they relate to medical scheme premiums are due to the existence of non-healthcare expenditure such as different administrators performing what is essentially the same functions. Reference in this regard is the presence of managed care companies in the administration of subsets of medical scheme benefits but performing a similar function to that of administrators. Other cost drivers that have no

[5] Gems Annual report 2015.

discernible healthcare outcomes is payments in respect marketing, advertising and brokers.

63. **With regard to the provision of dental services, we have already shown that prices are indeed distorted, but to the detriment of the providers through the de-facto collusion between medical schemes in setting tariffs that are below the cost of providing the service and uniform managed care protocols across medical schemes and options.**

Information failure applicable to funders

64. It is correct that consumers are faced with complex medical scheme and insurance arrangements and are completely oblivious to the managed care arrangements on their behalf. But that should be expected because the interest of the consumers is to receive quality healthcare in return for pre-payments. In short, the consumers purchase medical cover based on the good faith that the medical schemes will honour their obligations to the providers.
65. The complexity of the information is thus a deliberate act by medical schemes to take advantage of the ignorance of the consumers and to offer products of lesser value than what is believed (by the consumer) to be a good value product. For instance, there is generally very little difference by way of benefits between the different medical scheme and benefit options. The use of complex language is thus used to create illusion by the funders about the virtues or utility of a particular medical scheme benefit.
66. Managed care protocols in particular are not designed to be understood by the patients given that they wade into the arena of the providers. To complicate matters, they are generally remain unknown until a claim for payment is rejected by the medical scheme.
67. Providers are equally at a disadvantage given they have to understand the healthcare benefits of 83 medical schemes and several hundred options.

Information failures applicable to healthcare providers

68. Healthcare, dentistry included, is a complex science that the average person will not readily have an understanding of. However, to facilitate patient information and an understanding of the treatment process, it is incumbent on the providers of healthcare to simplify the science, and it our submission that providers to exactly that.
69. Necessarily, medical information is highly confidential and is protected by legislation. It is neither necessary nor desirable that such ethical practices be tempered with.

Agency failures applicable to funders

70. Non-health care expenditure is a significant component of the overall cost of healthcare and it accounts for at least 12 percent (12%) of GCI. Administration and managed care costs account for 9.7 percent (9.7%) of GCI and the rest is made up of marketing, advertising and broker costs[6].

[6] CMS Annual Report 2015.

71. It is intriguing that so many medical schemes, 70 out of 80 or 88 percent (88%), are administered by third parties. **According to the CMS annual report 2015, third-party administered schemes spent 41.9 percent (41.9%) more on administration and managed care than self-administered schemes.** There are clearly perverse incentives that are available to third-party to increase non-healthcare expenditure.
72. There is no doubt that there is an inherent misalignment of objectives and agency failure in the relationship between medical schemes and third-party administrators.

Agency failure in respect of providers

73. It is the submission of the DPA that the ethical conduct of healthcare providers such as doctors and dentists is sufficiently covered under the Health Professions Act with strict enforcement. The weakness in regulation is as it relates to corporate entities such as hospitals. There is simply no law that compels these entities to act in the interest of the patient as the most important principle and objective and this may give rise to agency failures.
74. The other aspect that may give rise to agency failures is the benefit design which may provide incentives to act in the manner that is not foremost in the interest of the patient. For example, the severe limitation of day-to-day benefits leaves providers (and patients) with no choice but to render the same service in the hospitals, at an exorbitant cost.

Market power through concentration

75. The existence of monopolies in any industry is an antithesis of perfect competition. The market mechanism of supply and demand which leads to a realistic price discovery becomes distorted. There is no question, just as the HMI has noted, that hospital groups, third-party administrators and pathology firms wield considerable monopoly power in the healthcare market.
76. There are other silent monopolies in the form of managed care companies. Reference has been made that in the dental managed care space, there are only two dominant players, namely Denis and DRC. These companies have been able to artificially drive down the prices for dental services and have manipulated demand for dental services through the so-called managed care protocols. This behavior allows them, not only to remain funders but also participate in the provision of dental services.
77. **The designated provider networks, such as the Denis Network, is an audacious attempt to exercise complete control over the market, both in funding and provision dental services. Managed care companies establish the networks through coercive tactics which are backed up by real financial sanctions and exclusion. In this way, managed care companies (through the networks) exclude a large portion of dental procedures from reimbursement and lock providers into vague open-ended contracts that are harmful to both the providers and the patients. The Denis Network contract is appended as annexure 4.**

Market power through collusion

78. There is widespread collusion in the private healthcare environment and the HMI is correct in investigating this practice.
79. The nature of dental practice in South Africa makes the practice of collusion, whether vertical or horizontal, very unlikely. The dental profession however suffers a great deal through the collusive practice of medical scheme administrators and managed care companies.
80. First, there is de-facto collusion by medical schemes regarding the tariffs applicable to dentistry which are generally similar. Secondly, the dental benefits and managed care protocols are very similar across most schemes, particularly where managed care is implemented. Medical schemes therefore do not compete on price and benefits (product), to the detriment of the consumer.
81. Another form of collusion happens when managed care companies or other suppliers in the healthcare supply chains are related to, or are subsidiaries of third-party administrators. This gives rise to cross-management of medical schemes at various levels which reduces competition through sweetheart deals.

Fragmented health delivery systems

82. The health markets across the world, in both the private and public sectors are generally fragmented which gives rise to duplication of services and rising costs. In the private health sector, it is fueled by sheer number of medical schemes and healthcare providers in the system. It does not necessarily impact on competition but to rising healthcare costs due to inefficiencies.

Barriers to entry, expansion and innovation

83. The HMI is correct in its assessment that there are significant barriers to entry in the healthcare, not only on the side of the funders but increasingly on the side of the providers such as hospitals, pathology and radiology groups. These entities are able through market power, vertical and horizontal relationships with role-players in the healthcare value chains.
84. **Of particular concern to the DPA is the complete market domination of the dental managed care market by a few corporate entities. This creates significant barriers to entry for new, innovative and low cost business models that are provider-led.**
85. **The designated provider networks have the potential of increasing barriers to entry for new dental practitioners.**

Government failure

86. The failure of government to adequately regulate the private health care system has led to emergence of monopolies which have in turn led to increased costs. It is our submission that healthcare is not fundamentally a private good that should be left to the private sector for its management. The widespread market failure that exists in the private health market,

such as the exclusion of the majority and the inverted health pyramid, where spending on tertiary health services and non-healthcare is greater than primary and secondary health services is indicative of a broken system.

87. The medical schemes act is also deficient to the extent that it only regulates the medical schemes but offers neither regulation nor safeguards to the providers of healthcare. In the same vein, the Health Professions Act is not applicable to medical schemes, who through managed care, have become de-facto providers of healthcare. The ethical burden of providing healthcare thus remains with the providers but the control of healthcare funding is ceded to the medical schemes and third party administrators.