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03 September 2018

The Health Market Inquiry

Inquiry Director

Advocate Clint Oellerman

VIA EMAIL: clinto@compcom.co.za

Cc: PaulinaM@compcom.co.za

Dear Advocate Clint Oellerman

RE: COMMENTARY ON THE SOUTH AFRICAN COMPETITION COMMISSION'S HEALTH MARKET INQUIRY: PROVISIONAL FINDINGS AND RECOMMENDATIONS REPORT 5th JULY 2018

Please find attached commentary from the Occupational Therapy Association of South Africa (OTASA) on the South African Competition Commission's Health Market Inquiry: Provisional Findings and Recommendations Report 5th July 2018. OTASA participated in the HMI process and made a verbal submission to the HMI Panel in 2016.

Introduction to OTASA and Occupational Therapy

OTASA is a non-profit professional association representing the interests of Occupational Therapists and Occupational Therapy Technicians/Assistants across South Africa. OTASA supports, promotes and represents the profession of occupational therapy (OT) as a key element of the health service provision in South Africa and positions itself as an integral, evidence-based and relevant force meeting society's health and occupational needs in partnership with key stakeholders and the public.

Introductory Comments:

It is our considered opinion that the Health Market Inquiry has fallen short in their definition and meaning of health in the South African context.

It appears that this Inquiry has focused only on the medical model of health, which has a curative stance and proposes diagnostic driven health care, with quick, cost effective medically derived and symptomatic outcomes. This narrow view is exacerbated by the sole use of the ICD 10 (International Statistical Classification of Diseases and Related Health Problems – Tenth Revision) coding system, with no mention of the ICF (International Classification of Functioning) and its importance in measuring outcomes in terms of impairment and long-term disability. South Africa's burden of disease show that the quadruple burden of disease – comprising of HIV and AIDS, non-communicable diseases (NCD's), communicable diseases and injuries is on average four times higher than that of developed countries and almost double that of developing countries (Econex, 2018). With improved access to medical treatment and rehabilitation, life expectancy may increase; and with a higher number of people experiencing chronic conditions/illness and disability, a larger burden is placed on the (health) economy, health infrastructure and human resources for health in South Africa. With this population of persons with chronic disease, quick, cost effective medical orientated outcomes (such as absence of symptoms) characteristic of a medical model are not an accurate reflection of health outcomes, as the health issues experienced by this population are more complex and long-term, impacting function and participation in everyday activities such as self-care, access to education, decent work and community participation. This proposed medical model aligns with the agenda of Medical Schemes where funding is the primary objective and where a system like the ICF, which focusses on health outcomes such as self-care, education, work and community participation is not considered. Individuals with chronic diseases, who have functional impairments or disabilities are often subjected to high out of pocket expenses or they must access the public sector services on the primary platform, when their limited chronic benefits are exhausted, to attend to their continuous health and rehabilitation needs. Thus, this focus on the medical model and curative care fails to serve the health needs of many, even those with medical scheme benefits.

1. Exclusion of OT and other healthcare providers from the Report

OTASA recognise that the HMI report focused on the cost drivers in the private healthcare sector, and the impact of regulatory failures, amongst others. As a result, it is understandable that this report on medical doctors and particularly medical specialists as is evident in Chapter 7 of the report. However, this highlights their dominance in this sector and the lack of consideration or

opportunity for other medical professionals who also contribute to the health of patients. It is indicative of this pervasive medical model that seemingly dictates health financing, the nature of care provision and how care is measured in terms of outcomes, making the health market a very restricted and uncompetitive space. Occupational Therapy services are among the lowest expenditure categories of medical schemes, but nonetheless find themselves, and their patients, at the receiving end of benefit design and managed care that fails to appreciate the value of occupational therapy or even its difference from physiotherapy and psychology, for example. This speaks to two key indicators of the inquiry, namely information asymmetry and market power, both of which practitioners such as occupational therapists, lack.

Table 3.4 includes only some, but not all the Professional Boards of the HPCSA. Our Professional Board (Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics and Art therapy) along with information on number of occupational therapy practitioners registered within the country is absent from the data presented in this Inquiry.

2. Licencing

In the context of the report, the licensing proposal relates to the regulatory failures of the hospital licensing system, and a system to ensure the allocation of practice code numbers, over time only to group practices. It should be noted that these proposals will affect OTASA, all though its members have not been implicated in the Report. OTASA do support the licencing of occupational therapy services, whether they are in the private or public sector and whether the practices are large or small, if there is capacity to do so, it is not onerous and the existing legal framework (section 36ff in the National Health Act, 2003 (NHA)), is updated.

2.1 Certificate of need (CON)

We understand that the Report recommends that a Supply Side Regulator for Health (SSRH) be established. The function of the SSRH is to be responsible for information relating to the number, type and distribution of HCP's. These functions also include the licencing of HCP's and providing practice numbers. The Report further proposes that that CON under the NHA be implemented to comply for the constitutional right to access to healthcare.

We see a few issues with the proposed functions of the SSRH:

1. There is a clear duplication of functions with the existing DoH, which is already responsible for the licencing of HCP's. In addition, the HPCSA is responsible for individual practitioner registration. Setting up another body may be costly and result in unnecessary delays.

2. We also anticipate that the SSRH taking over the practice code numbering would also be costly, if it is attempted to be used as a tool to ensure greater uptake of the concept of group- and multi-disciplinary practices.

We recommend that instead of taking over the above roles by the SSRH from established institutions, that the HMI rather identify issues that exist and make recommendations on how to address the shortfalls in the current systems, i.e.:

1. Harmonising the BHF System with the PCNS and the HPCSA.
2. Licencing to prevent anti-competitive practices.

Our concerns with the Certificate of Need is that as it would then be applicable to occupational therapy and will be required before a new practice is opened. OTASA is therefore not in favour of this and would like to raise the following concerns:

a. It is a concern how it will impact families, should occupational therapists be required to set up practice far from where he/she lives. This can also incur extra costs for the occupational therapist, should she/he not live close to the area in which she/he is allowed to practice.
b. The certificate of need is likely to impact the value of existing practices, which will affect selling of practices.
c. Should an existing practice be required to relocate because of the certificate of need, it will have an impact on staffing, as not all staff will be willing to move with the practice. This will automatically incur hardship and extra costs associated with training of new staff and losing expertise.
d. The needs of patients may suffer due to the red tape and bureaucracy to establish an occupational therapy practice in an area. The patients may need immediate service, but, due to administrative issues may go untreated.
e. We also consider this type of control to be uncompetitive as it would limit the right of patients to access an occupational therapist of their choice or receive treatment from an occupational therapist with specialised skills set or special interest and experience.

Therefore, OTASA recommends that, insofar as licensing is recommended as a remedy to market distortion, its blanket application to fields of healthcare service provision not found to be exploitative, or market-distorting, should not be included by inference because of section 36 of the NHA.

3. Health technology assessment

The HMI reported that there was no evidence of publicly available cost-effective standards of care in the heath sector and processes of conducting health technology assessments. The HMI also proposes that these be publicised to all. While we support the need for access to HTA's in order to provide patients with latest and innovative health technology, we differ with the HMI in the following aspects:

1. Making HTA accessible to the public (patients) will create transparency, however we see no need for this as it may create unethical disguised promotion of products and may also affect the HCP's autonomy to prescribe in the interest of the patient if the patient is already convinced of a specific product.
2. HTA be housed under SSRH. HTA should remain private and independent. Being housed under the SSRH as proposed may impact on the independence and accuracy of results due to the risk of undue influence by stakeholders of SSRH.

In this respect, our stance is that the HMI should rather recommend how the protocols and HTA must be implemented. Further, and considering the definition of health technology, as the application of organized knowledge and skills in the form of medicines, medical devices, vaccines, procedures and systems developed to solve a health problem and improve quality of life, occupational therapists undoubtedly play a crucial role in health technology assessment (http://www.who.int/health-technology-assessment/en/). Occupational Therapists utilise health technology assessments as part of their day-to-day evidence-based practise with the persons served.

3. Protocol development

HMI also reported that there isn't evidence of publicly available standards of care, evidence-based treatment protocols. However, protocols and standards of care do exist and are developed by professional societies in South Africa and internationally. However, often when developed, these protocols do not include the role of occupational therapy and similar healthcare services, which are also critical in the patient recovery.

The National Health Insurance (NHI) requires co-ordination of health provision across sectors and levels of care. Clinical practice guidelines (CPGs) are tools for standardising and implementing care and are intended to influence clinical decision-making with consequences for patient outcomes, health system costs and resource use. Under NHI, CPGs will be used to guide the provision of healthcare for South Africans. OTASA supports the use of clinical practise guidelines

that are contextually relevant as opposed to protocols that are by nature rigid and specific to a particular context.

The current protocols used in the private health sector, e.g. by medical schemes, should be reviewed and where appropriate adjusted to reflect the multi-disciplinary nature of health care within the broader context of health rather than just the medical model. In this context multi-disciplinary should not just reflect interventions by different types of doctors and specialist but recognise and give credit to the specifically different contribution different professions make to the health care delivery to patients. These clinical practise guidelines should be developed and reviewed in a multi-professional context with the patients' long-term health interest in mind, acknowledging the functional nature of ill health and the regaining of function in health and wellness. CPGs should be reviewed considering the best evidence that is appropriate to the South African context and different levels of evidence should be acknowledged, especially where evidence appropriate to the South African context is lacking. OTASA strongly recommends that professional bodies, including OTASA, academics, professional boards and the persons served be included in the development of these CPGs.

In terms of treatment guidelines, The use of evidence-based practise in occupational therapy is furthermore endorsed by the Minimum Standards for Practice (Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics, 2004), the World Federation of Occupational Therapists Code of Ethics (World Federation of Occupational Therapists, 2004) and the Occupational Therapy Code of Ethics and Professional Conduct for practice in SA (Occupational Therapy Association of South Africa, 2005). It will therefore be essential to include occupational therapy in HTA to also ensure consistency between the public and private sector and to benchmark standards already available in the public sector, such contained in the National Core Standards and Ideal Clinic requirements as well as the Framework and Strategy for Disability and Rehabilitation Services in South Africa (2015), which provide a set of norms and standards for occupational therapy and other rehabilitation professionals. Occupational Therapy furthermore has a range of contextually relevant evidence on HTA that can be accessed via the South African Journal of Occupational Therapy (http://www.sajot.co.za/index.php/sajot). The below-mentioned are also two examples of where information on HTA in occupational therapy can be accessed:

- http://www.otseeker.com/

  OTseeker is a database that contains abstracts of systematic reviews, randomised controlled trials and other resources relevant to occupational therapy interventions. Most trials have been critically appraised for their validity and interpretability.

- https://srs-mcmaster.ca/research/evidence-based-practice-research-group/

The McMaster Occupational Therapy Evidence-based Practice group focuses on research to critically review evidence regarding the effectiveness of occupational therapy interventions and to develop tools for evaluation of occupational therapy programmes.

4. Outcome (OMRO)

OTASA supports the development of outcomes to advance quality health care. However, outcomes for a professional service should define and delineate the distinct value and role of that service, in this case occupational therapy. Quality outcomes are not easy to develop and should be based on rigorous contextual research with specific outcome measures that are psychometrically sound and provide the evidence for efficacy and efficiency. OTASA asserts that occupational therapy outcomes that measure the quality of an occupational therapy service should not be squeezed into outcomes that describes the role of a doctor - which seems to currently be the way in which Medical Funders understands them, and which links back to the definition of health, which in this Inquiry is narrowly approached from a Medical Model.

OTASA welcomes the recommendation that OMRO starts in phases, and whit what is already available. In this regard we would like to point out that The South African Database of Functional Medicine (SADFM) is an outcomes measure that has a battery of tools to measure the functionality of patients/clients/users across the healthcare continuum. It is used by approximately 60 private facilities in South Africa and is based on the World Health Organization's guidelines of "organs and systems, activity and participation". There are several outcome measures in this system, one of them including the Activity Participation Outcome Measure (APOM) which can only be used by occupational therapists. The APOM is also a stand-alone measure (if the facility is not using the SADFM system, they can still have the APOM only). OTASA asserts that the outcome measures applied in our context must be standardised across the public and private sector and must be validated for the South African population, such as the case with the SADFM. A list of references where the SADFM has been validated for use in South Africa is attached hereto as Annexure "A".

Professor Daleen Casteleijn, Associate Professor at the Occupational Therapy Department of the University of the Witwatersrand has a data base containing information on with mental illnesses from selected private and public health care facilities in South Africa (and the UK) with respect to the functional status of people with mental illness, the rate of improvement per diagnostic groups, the type of intervention that was provided to obtain the improvement and the expected rates of change (predictions) of specific disorders. This information can be obtained from Professor

Daleen Casteleijn, Associate Professor at the Occupational Therapy Department of the University of the Witwatersrand at: Daleen.Casteleijn@wits.ac.za.

We also recommend that where there are already institutions that can be responsible for measuring and reporting outcomes such as the proposed OMRO, existing structures must be used for this purpose and save cost and delays that will be caused by setting up OMRO. This with the recommendation that outcomes for OT not be defined similar to those of other healthcare providers as motivated above. Rather identify any failures of existing entities and correct them instead of setting up a complete new entity.

5. Setting of fees

It is the view of OTASA that the tariffs set for occupational therapy services must be negotiated with the representative body of the profession, namely OTASA, as well as the regulatory Board. However, adequate exemption from the Competition Act would be required, and the association empowered to also collect and deal with data, and powerful players be required to disclose data relevant during such a negotiation (e.g. funding levels of OT, patients with specific diagnoses landing up in hospitals, etc.). Neither system is recommended (regulated pricing or negotiated pricing) or accepted if the process to determine and enforce tariffs is not open, fair, equitable and transparent. Setting of tariffs will not be acceptable if the power of funders and other more dominant professions or any conflicted occupational therapist or group are not excluded from this process.

6. PMB

“The HMI found high compliance levels amongst the funders in paying for in-hospital PMB cover. This was not surprising given that medical schemes typically cover in-hospital events in full irrespective of PMBD status”. The HMI found in contrast to in-hospital PMB’s that funders are less compliant with out of hospital PMB funding and increased payment of the out of hospital PMB’s out of savings.

Occupational therapy is often not funded out of risk, even if undertaken as part of the treatment and care of a PMB condition. It remains a constant battle of OT’s in private practice to motivate for, and get reimbursement, for PMB care. As OT services are also rendered out of hospital, OTs and their patients are at the receiving end of PMBs not being funded or funded from savings.
The lack of understanding of the role of OTs, also often result in benefit design that leads to OTs having to compete with “supplementary benefits”, shared with physiotherapists, psychologists, podiatrists, etc.

This report is respectfully submitted by the OTASA Executive Committee.

Kind regards,

Prof Pat de Witt (MSc OT, PhD Wits)
President

Annexure A

1. Van der Linde J & Casteleijn D. A comparison of two assessments of levels of functioning in clients with intellectual disability between occupational therapists and nursing staff within a long-term mental healthcare facility in South Africa. Curationus, 2016 vol 39 (1): a1665. http://dx.doi.org/10.4102/curationis.v39i1.1665
2. Loubser H, Casteleijn D, Bruce J. The GAMMA® nursing measure: calibrating construct validity with Rasch analyses. Health SA Gesondheid, 2016 vol 21: 11- 20
3. Loubser H, Casteleijn D, Bruce J. The BETA® nursing measure: calibrating construct validity with Rasch analyses. Health SA Gesondheid, 2015 vol 20: 22 - 32.
4. Van Biljon H, Du Toit S & Casteleijn D. Developing a Report Writing Protocol for Occupational Therapy Vocational Rehabilitation Services in Gauteng Public Healthcare through action research. South African Journal of Occupational Therapy, 2015 vol 45 (2).
5. Casteleijn D. Using measurement principles to confirm the levels of creative ability as described in the Vona du Toit Model of Creative Ability. South African Journal of Occupational Therapy, 2014 vol 44(1), 14 – 19.
6. Loubser H, Bruce J, & Casteleijn D. The GAMMA nursing measure: its development and testing for nursing utility. Health SA Gesondheid, 2014 vol 19(1) 9 pages. http://dx.doi.org/10.4102/hsag.v19i1.749
7. Loubser H, Casteleijn D & Bruce J. The DELTA nursing measure: its development and testing for nursing utility. Health SA Gesondheid, 2013 vol 43 18(1) 9 pages. http://dx.doi.org/10.4102/hsag.v18i1.699
8. Casteleijn D. The Vona du Toit Memorial Lecture: The stepping stones from input to outcomes: an occupational perspective. South African Journal of Occupational Therapy, 2013 vol 43 (1), 2-9.
9. Loubser H, Bruce J, & Casteleijn D. The BETA nursing measure: its development and testing for nursing utility. Health SA Gesondheid, 2013 vol 43 18(1) 9 pages. http://dx.doi.org/10.4102/hsag.v18i1.697
10. Casteleijn D & Graham M. Incorporating a client-centered approach in the development of an occupational therapy outcome measure for mental health care settings in South Africa. South African Journal of Occupational Therapy, 2012 vol 42 (2), 8-13.
11. Casteleijn D & Graham M. Domains for occupational therapy outcomes in mental health practices. South African Journal of Occupational Therapy, 2012 vol 42 (1), 26 – 34.

In addition, the below mentioned contains a list of Masters' level studies in occupational therapy at the WITS university, specifically focussing on outcome measurement:

1. Brooke C. 2015 Selected psychometric properties of the activity participation outcome measure to describe trends in a forensic population of mental health care users. URI: http://hdl.handle.net/10539/18684
2. Camp, A. 2015. The responsiveness and relevance of the activity of the participation outcome measure in patients with traumatic brain injury in an acute neurological rehabilitation setting. URI: http://hdl.handle.net/10539/18668
3. Pillay, S. 2016. Responsiveness to change and convergent validity of the activity participation outcome measure (APOM) in adolescent mental health care users. MSc study University of the Witwatersrand. URI: http://hdl.handle.net/10539/21311.
4. Silaule, O. 2016. Routine measurement of outcomes for mental health care users attending occupational therapy. MSc study University of the Witwatersrand. URI: http://hdl.handle.net/10539/23305
5. Wolhuter, KA. 2014. The impact of adolescence initiated alcohol and cannabis abuse/ dependence on the level of activity participation in adult males suffering from a psychotic disorder. MSc study University of the Witwatersrand. URI: http://hdl.handle.net/10539/17399
6. Nepaul, Q. 2017. The association between substance abuse, psychosis and activity participation in adults: a retrospective record review. MSc study University of the Witwatersrand.