ALLIED HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

SUBMISSION TO THE COMPETITION COMMISSION REGARDING THE MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

OCTOBER 2014

SECTION A: INTRODUCTION AND OVERVIEW OF THE ALLIED HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA AND ALLIED HEALTH PROFESSIONS

1. THE ALLIED HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (AHPCSA)

1.1 THE ALLIED HEALTH PROFESSIONS ACT, ACT 63 OF 1982, AS AMENDED ('THE ACT')

The Allied Health Professions Council of South Africa (AHPCSA) is a statutory health body and juristic person established in terms of the Allied Health Professions Act, 63 of 1982 (the Act) in order to regulate certain allied health professions, or, according to international terminology, complementary healthcare professions.

Registration with the AHPCSA confers on registered persons the right and privilege to practise those allied health professions for which they have been registered in terms of the Act, for gain.

1.2 PROFESSIONS REGULATED BY THE AHPCSA

- Ayurveda;
- Chinese Medicine and Acupuncture;
- Chiropractic;
- Homeopathy;
- Naturopathy;
- Osteopathy;
- Phytotherapy;
- Therapeutic Aromatherapy;
- Therapeutic Massage Therapy;
- Therapeutic Reflexology; and
- Unani-Tibb.

A brief overview of these professions may be accessed at www.ahpcsa.co.za > Professional Boards > PBACMU / PBARM / PBCO / PBHNP.

1.3 STRUCTURE OF THE AHPCSA

The Act provides for the constitution of the AHPCSA Council, comprising eleven members elected from each of the allied health professions and six others: four community members, one person with legal knowledge and one National Department of Health representative, all appointed by the Minister of Health.

The Act also provides for the constitution of four professional Boards:

- Professional Board: Ayurveda, Chinese Medicine and Acupuncture and Unani-Tibb;
- Professional Board: Chiropractic and Osteopathy;
- Professional Board: Homeopathy, Naturopathy and Phytotherapy ; and
- Professional Board: Therapeutic Aromatherapy, Therapeutic Reflexology and Therapeutic Massage Therapy,

on which each profession is represented by two elected members of that profession and one community representative appointed by the Minister of Health, who is also a council member.

1.4 SCOPE OF PRACTICE

Section 2 of the Act provides as follows:

(a) a practitioner may-

(i) diagnose, and treat or prevent, physical and mental disease, illness or deficiencies in humans;
(ii) prescribe or dispense medicine; or
(iii) provide or prescribe treatment for such disease, illness or deficiencies in humans;

(b) a therapist may-

(i) treat or provide treatment for diagnosed disease, illness or deficiencies in humans; or
(ii) prevent such disease, illness or deficiencies in humans;

1.5 DIAGNOSTIC PRACTITIONERS

Diagnostic practitioners are registered in the professions of: Ayurveda, Chinese Medicine and Acupuncture, Chiropractic, Homeopathy, Naturopathy, Osteopathy, Phytotherapy, and Unani-Tibb.

1.6 NON-DIAGNOSTIC THERAPISTS

Non-diagnostic therapists are registered in the professions of: Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology.

1.7 EDUCATION AND TRAINING

Minimum requirements for education and training, as provided for in the Act are:

- A Master's degree (Chiropractic and Homeopathy), offered at the Durban University of Technology and the University of Johannesburg;
- A double Professional Bachelor's degree (Chinese Medicine and Acupuncture, Naturopathy Phytotherapy and Unani-Tibb), offered at the University of the Western Cape; and
- A diploma (240-credits) (Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology), offered by private providers of education and training.

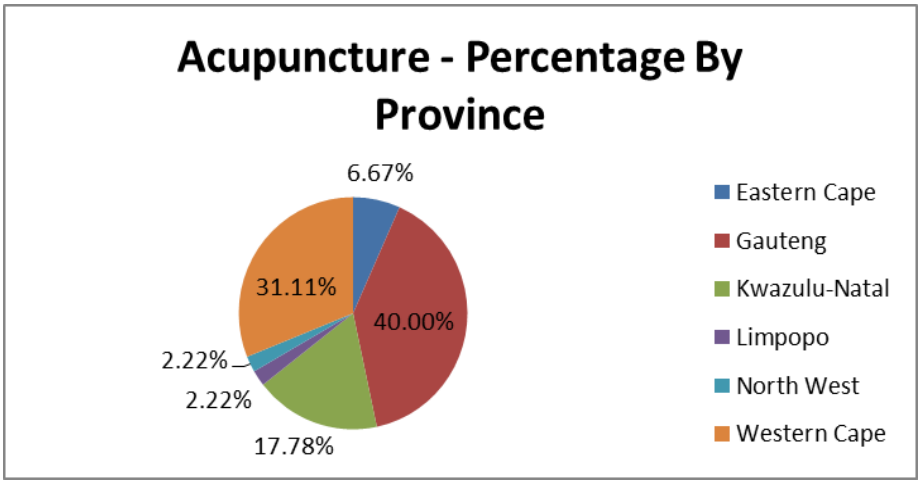
Education and training in the professions of Ayurveda and Osteopathy are not offered in South Africa, but the Act provides for a Professional Bachelor's degree for Osteopathy, whereas, in the case of the profession of Ayurveda, a five-year foreign qualification, such as the Bachelor of Medicine and Surgery (BAMS) degree is the minimum requirement. A diploma (360-credits) is provided for in the Act for persons wishing to practise Acupuncture only, but no such qualification is offered in South Africa at this stage.

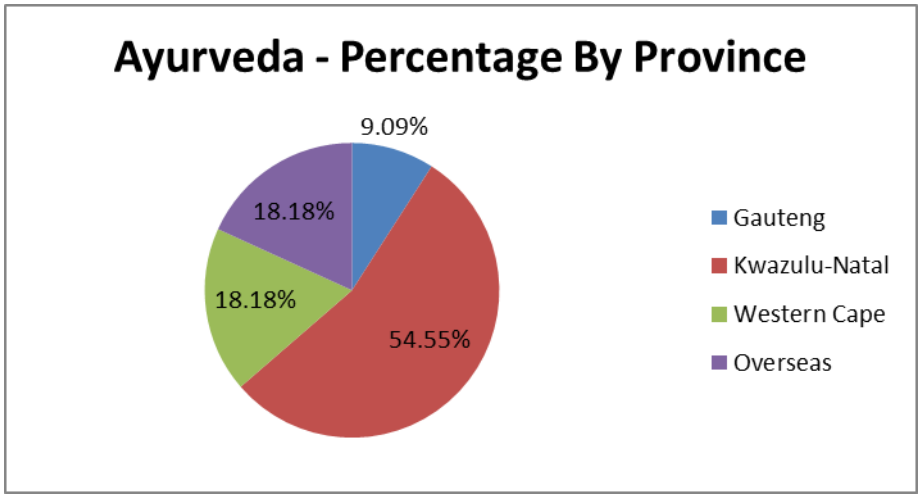
1.8 REGISTRATION STATISTICS

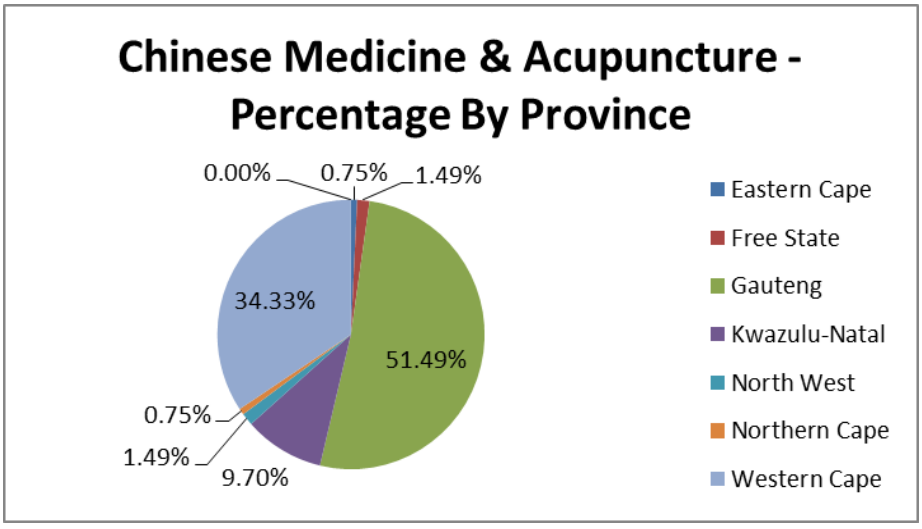
Statistics of persons registered in the various professions as at 28 October 2014 are:

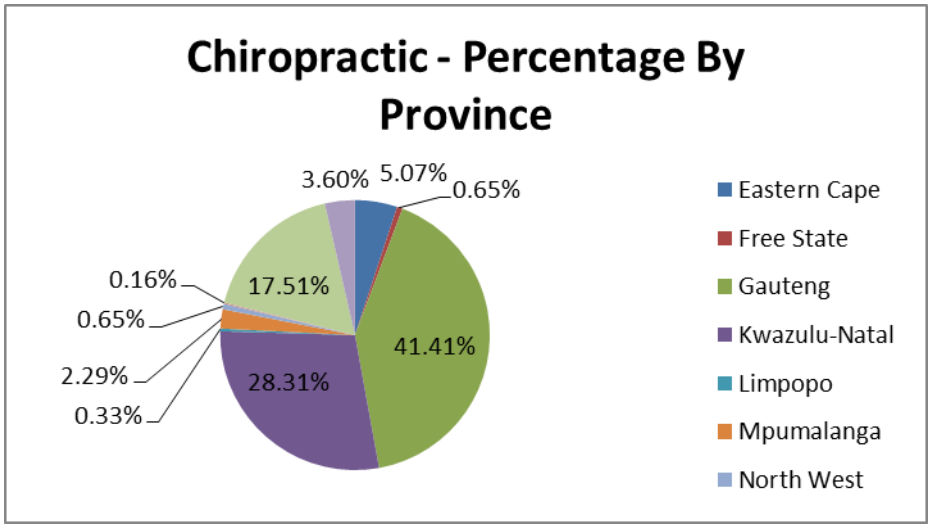
PROFESSION	**NUMBER**
Acupuncture	65
Ayurveda	16
Chinese Medicine and Acupuncture	158
Chiropractic	701
Homeopathy	565
Naturopathy	92
Osteopathy	43
Phytotherapy	41
Therapeutic Aromatherapy	196
Therapeutic Massage Therapy	126
Therapeutic Reflexology	594
Unani-Tibb	70
TOTAL	**2667**

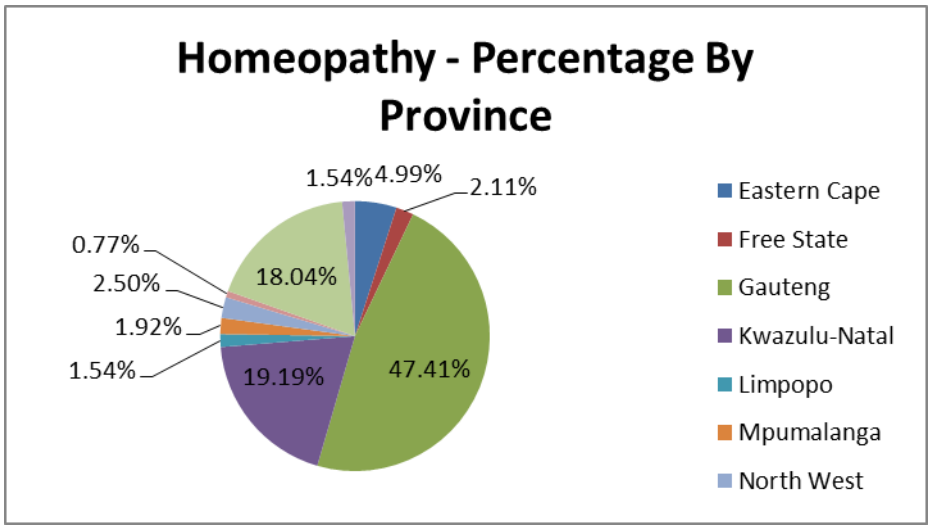
1.9 GEOGRAPHICAL DISTRIBUTION OF THE PROFESSIONS

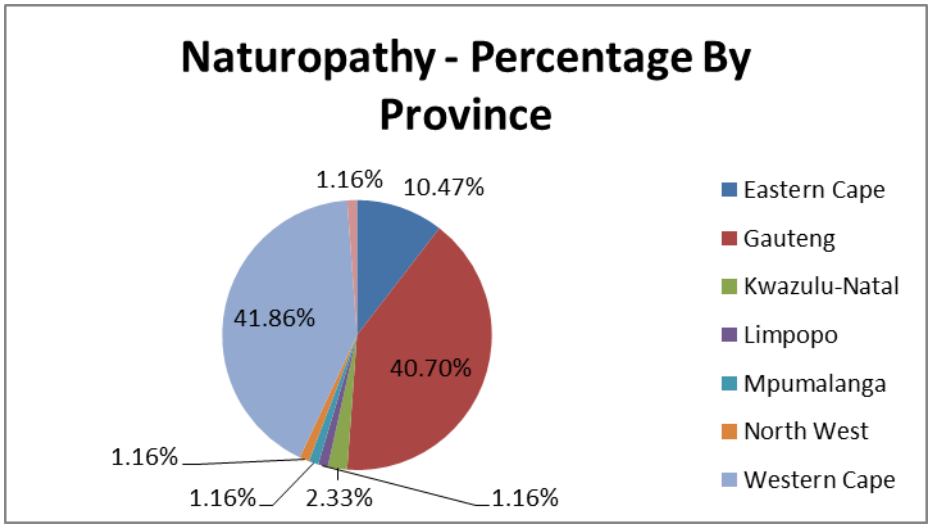


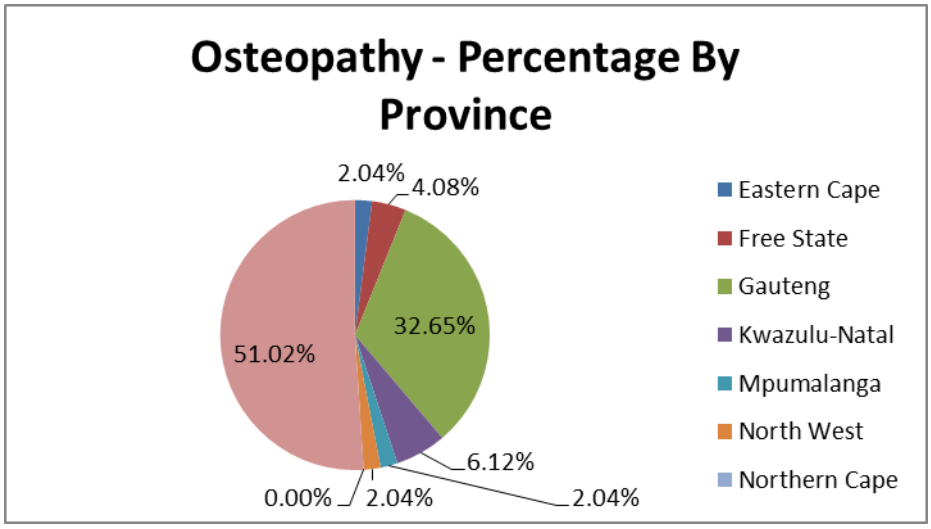


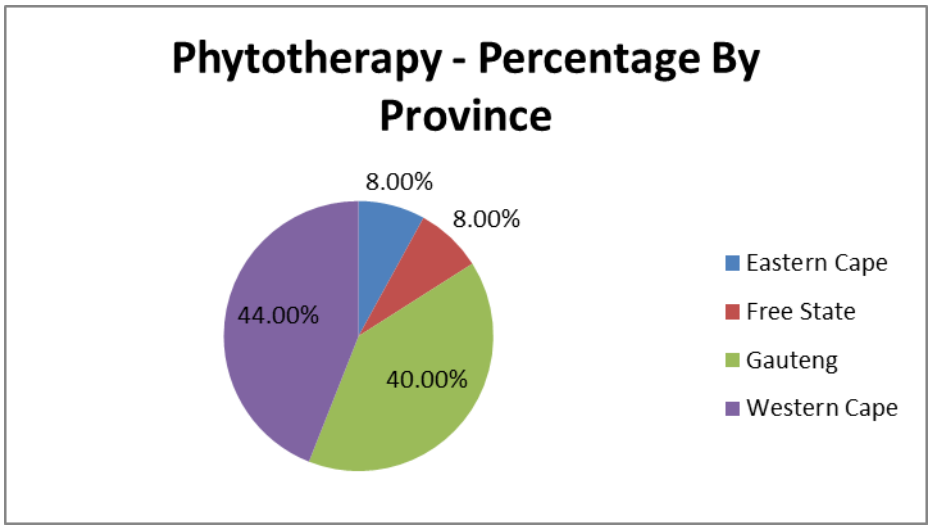


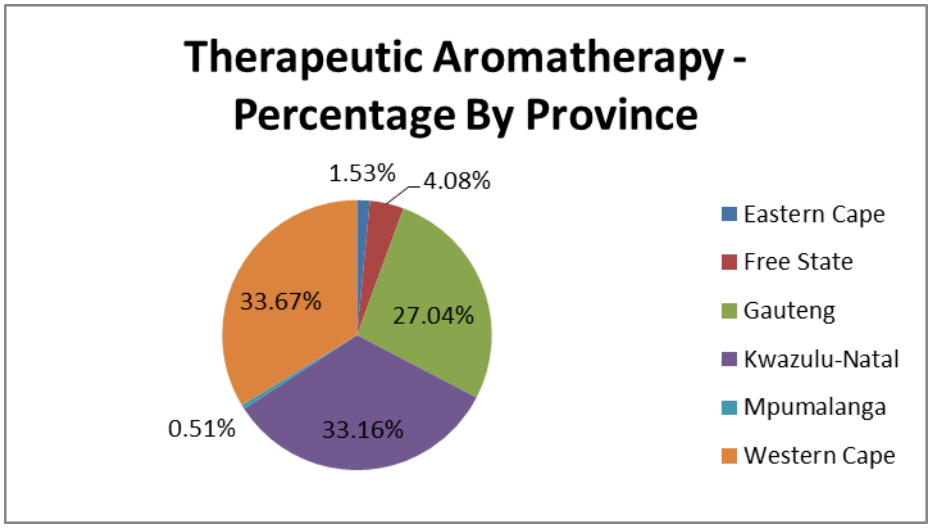

Chiropractic - Percentage By Province
3.60%
5.07%
0.65%
0.16%
17.51%
0.65%
41.41%
2.29%
28.31%
0.33%
Eastern Cape
Free State
Gauteng
Kwazulu-Natal
Limpopo
Mpumalanga
North West

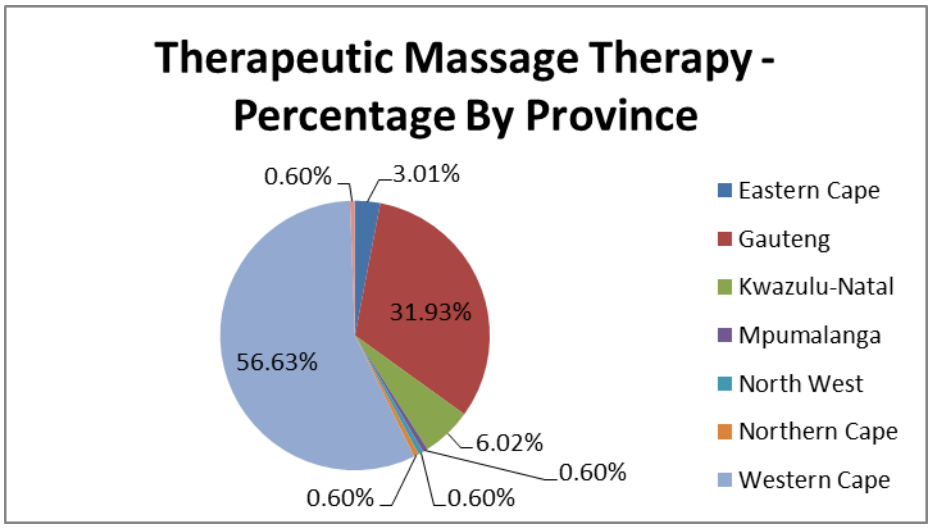

Homeopathy - Percentage By Province
1.54%
4.99%
2.11%
0.77%
18.04%
2.50%
1.92%
1.54%
19.19%
47.41%
Eastern Cape
Free State
Gauteng
Kwazulu-Natal
Limpopo
Mpumalanga
North West

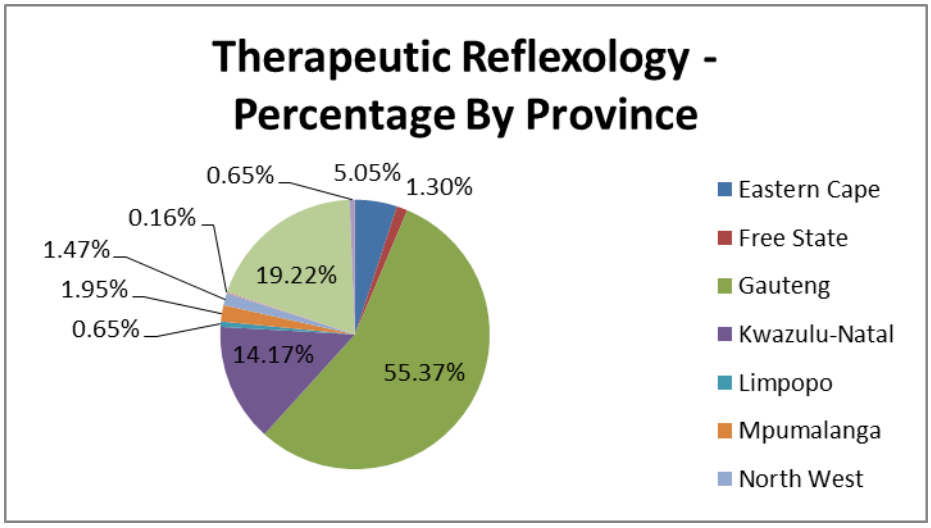

Naturopathy - Percentage By Province
1.16%
10.47%
41.86%
40.70%
1.16%
1.16%
2.33%
1.16%
Eastern Cape
Gauteng
Kwazulu-Natal
Limpopo
Mpumalanga
North West
Western Cape

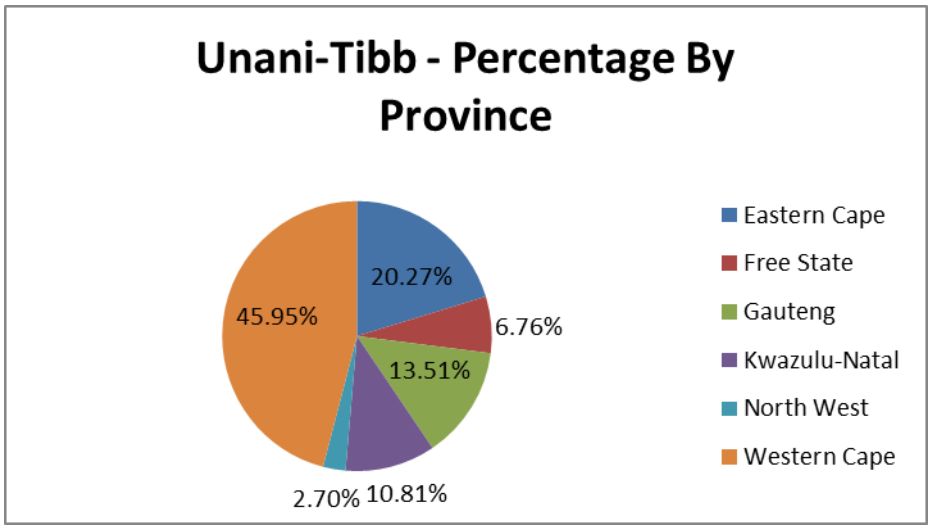

Osteopathy - Percentage By Province
2.04%
4.08%
32.65%
51.02%
6.12%
0.00%
2.04%
2.04%
Eastern Cape
Free State
Gauteng
Kwazulu-Natal
Mpumalanga
North West
Northern Cape


Phytotherapy - Percentage By Province
8.00%
8.00%
44.00%
40.00%
Eastern Cape
Free State
Gauteng
Western Cape


Therapeutic Aromatherapy - Percentage By Province
1.53%
4.08%
33.67%
27.04%
0.51%
33.16%
Eastern Cape
Free State
Gauteng
Kwazulu-Natal
Mpumalanga
Western Cape


Therapeutic Massage Therapy - Percentage By Province
0.60%
3.01%
31.93%
56.63%
6.02%
0.60%
0.60%
0.60%
Eastern Cape
Gauteng
Kwazulu-Natal
Mpumalanga
North West
Northern Cape
Western Cape


Therapeutic Reflexology - Percentage By Province
0.65%
5.05%
1.30%
0.16%
1.47%
19.22%
1.95%
0.65%
14.17%
55.37%
Eastern Cape
Free State
Gauteng
Kwazulu-Natal
Limpopo
Mpumalanga
North West


Unani-Tibb - Percentage By Province
20.27%
45.95%
6.76%
13.51%
2.70%
10.81%
Eastern Cape
Free State
Gauteng
Kwazulu-Natal
North West
Western Cape

SECTION B: ALLIED HEALTH PROFESSIONS COUNCIL RESPONSE TO THE ISSUES IDENTIFIED IN THE COMPETITION COMMISSION STATEMENT OF ISSUES

1. PROFESSIONAL BOARD: HOMEOPATHY, NATUROPATHY AND PHYTOTHERAPY (PBHNP)

The PBHNP, after due consideration, has submitted the following comprehensive response, which is encompassed in sub-paragraphs 1.1 to 1.47.

Although professions-specific in parts, it should be noted that the issues identified in the PBHNP response are applicable to all allied health professions, including therapeutic professions and will therefore not be repeated, and matters additional to the PBHNP response pertinent to this inquiry and raised by the other professional boards, namely those from:

- Professional Board: Ayurveda, Chinese Medicine and Acupuncture and Unani-Tibb;
- Professional Board: Chiropractic and Osteopathy; and
- Professional Board: Therapeutic Aromatherapy, Therapeutic Reflexology and Therapeutic Massage Therapy

will be addressed from paragraph 2 below onwards.

1.1 The PBHNP recognizes that the Competition Commission's focus is on the private health care system of South Africa. From a complementary and alternative medicines (CAMS) perspective and the PBHNP perspective, the issues facing the CAMS professions are systemic and therefore include both the private and public sectors. They are both discussed hereunder as the one sector influences the behaviour of the other.

1.2 The lack of accessibility of CAMS practitioners into the public health system is perpetuated by the iniquitous manner in which the private medical schemes cover the services of CAMS practitioners. The CAMS practitioners in the private practice only account for approximately 0.14% of expenditure.

1.3 The current healthcare paradigm where allied health practitioners are not part of the public health care system has resulted in allied health professions being able to address the health needs of South Africans through private practice only. Practitioners usually practice in urban areas where the professions are known and their services can be paid for by the individual or be reimbursed, either partially or fully, usually only partially or minimally and in the case of certain professions, not at all, by a medical aid.

1.4 Medical aid providers often determine what they will pay, if at all, for CAMS services. The lack of understanding of the CAMS professions and the low level of knowledge results in limited, poor or no re-imbursement for CAMS services. As in the public sector, the private sector makes no provision for representation of CAMS professions.

1.5 When a comparison is made to one of the BRICS countries, for example India, CAMS is part of the national health care strategy. A government department exists within the Ministry of Health and Family Welfare and is dedicated to CAMS in that country. The Department of Indian Systems of Medicine and Homeopathy (ISM&H) was created in March 1995 and renamed AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003. There is a Cabinet Minister that represents these professions. The professions of AYUSH and their therapeutics are governed and regulated both by the central government and the 27 states in India. Professionals are employed by the state and various hospital and clinics are provided to treat the public with AYUSH medicines and therapies.

1.6 As mentioned above in Section A, the AHPCSA is constituted in terms of the and allied health professions are registered in diagnostic professions (practitioners) and in non-diagnostic professions (therapists).

1.7 Beyond this, these professions have no representation at the Departments of Health, National (NDoH) or Provincial (PDoH), or at Parliamentary level. The AHPCSA does not enjoy an adequate level of interaction with the NDoH and many of its concerns and queries remain unanswered.

1.8 Further South African public tertiary institutions of education and training only provide for the education and training of six of the eight diagnostic professions resorting under the AHPCSA, Acupuncture (as stand-alone qualification), Ayurveda and Osteopathy excepted.

1.9 The graduates from these institutions have no access to an internship and have not been accommodated by the NDoH or PDoH.

1.10 Despite the shortage of medical personnel and the fact that the state subsidizes the education and training of CAMS practitioners in this country, their skills are not being utilized by the state. This relates to the fact that there is no representation of CAMS at respective governmental levels. There is little knowledge of these professions and a concomitant disregard for their benefits and role in primary health care.

1.11 This has permeated into the private health sector as well. Medical aid providers and administrators pay disproportionately for complementary medicine services, or not all. As in the public sector, the private sector also does not have knowledgeable persons advising on complementary medicines and make decisions without consultation. The complementary medicine costs to medical aids are negligible when compared to mainstream medicine, yet medical aids consistently and continually reduce complementary member benefits.

1.12 The fact that medical aid providers/administrators reduce or do not pay for complementary medicines must be considered anti-competitive as members of these schemes are in effect coerced to use only one paradigm of medicine. If they choose to use complementary medicine there will be little or no reimbursement. In effect, this is in conflict with their right of choice of treatment.

1.13 Medical aid providers/administrators have very little or no knowledge of the CAMS healthcare paradigm and further little or no effort in considering these systems as effective health systems that require the same reimbursement.

1.14 Administrators of these medical aids have on their advisory panels mainstream-trained doctors overwhelmingly (it is doubted whether there is any appointment to any advisory panel of a complementary medicine practitioner), who steer decisions and policies according to their inherent therapeutic bias, which is to the detriment of complementary medicine practitioners and to the members of the scheme.

1.15 Where schemes should be looking at pooled risk and determine what each member is allocated and being able to use that allocation by visiting a practitioner of their choice, they are in effect forced to use a conventional-medicine model unless they are willing to pay out of pocket. The cost of belonging to a medical aid scheme is already high and this is an additional burden for a citizen who wants to exercise his right of choice.

1.16 Some medical aid schemes refuse to pay for radiology and pathology services that can lead to compromised care when a member of that scheme chooses to use a complementary medicine practitioner. Instead the patient is forced to use a conventional-medicine practitioner if he/she wishes to be reimbursed.

1.17 This perpetuates the prejudicial manner of schemes and promotes anti-competitive behaviour. It also creates in the public mind that our services and qualifications are inferior as the medical aid reimburses a conventional-medicine practitioner, but not an allied health professions practitioner as defined in the Act.

1.18 Medical aid schemes are therefore further skewing the accessibility and affordability of complementary medicines.

1.19 The NDoH in its documentation continually refers allied health services, not in reference to professions registered under the AHPCSA, but rather to professions (other than conventional-medicine practitioners) registered with the Health Professions Council of South Africa (HPCSA), such as the professions of radiography, dieticians, physiotherapy, and psychology to name but a few.

1.20 The Act defines and registers “allied health professions” and the the Genesis Report[1] is pertinent in this context.

[1] [Genesis Healthcare Market Background paper, 31 August 2012 Genesis Analytics (Pty) Ltd. http://www.healthinquiry.net/Public%20Documents/Genesis%20healthcare%20background%20report.pdf (accessed 24-10-2014)

1.21 The Genesis Report refers AHPCSA-registered professions as “supplementary healthcare providers” (Appendix 3 page 93), mentioning that the Act defines ten categories of “allied health professions”. Subsequently an additional profession of Unani Tibb was added.

1.22 The Genesis Report includes professionals registered with the AHPCSA as “supplementary healthcare providers” (Appendix 3 page 93): *Acupuncture & Chinese Medicine, Ayurvedic Practitioners, Chiropractors and Osteopaths, Homeopaths, Naturopaths, Phytotherapists, Massage, Aromatherapy and Reflexology.*

1.23 It should be noted that professionals registered with the AHPCSA are either “practitioners” or “therapists.” Practitioners, while registered, may use the title “doctor.” Their skills include diagnostic and clinical examination skills (including internal examinations). Practitioners are specifically mentioned and defined as such both in the Act, in the Schedules of Medicines and in Regulations to the Medicines and Related Substances Amendment Act, 1965 (Act 101 of 1965), and as healthcare providers in Section 1 of the National Health Act (Act 61 of 2003).

1.24 Appendix 5 (page 110) of the Genesis Report refers to the compound annual growth rate (CAGR) of some of the professions (based on data from the Council for Medical Schemes), the proportion of total healthcare expenditure on allied health professions is minimal, as may be seen from the following table:

	Total Nominal Healthcare Expenditure (Rm)		Nominal CAGR	Real CAGR	Proportion of total healthcare expenditure (nominal)	
Profession	2004	2010	2004-2010	2004-2010	2004	2010
Acupuncture & Chinese	0	2	202%	184%	0.00%	0.00%
Chiropractors & Osteopaths	34	85	16%	9%	0.08%	0.10%
Homeopaths	18	37	12%	6%	0.04%	0.04%
*Other support & allied health professionals (sic)	311	2331	40%	40%	0.76%	2.75%

* These do not include any professions registered with the AHPCSA. They refer to: “Art Therapy, Audiology, Biokinetics, Clinical technologists, Hearing Aid Acousticians, Pharmacists, Radiographers and social workers, as well as Laboratory Technologists.”

1.25 According to these figures, in 2010, the combined pay-outs to allied health professions registered under the AHPCSA were R124m and the nominal proportion of healthcare expenditure was 0.14%, as was pointed out above.

1.26 Part of the reason for this minimal expenditure is that in 2004 and 2010 the number of registered professionals was *x* and *y* respectively. In October 2014 it is 2667. Of these, the “practitioners” are 1753. [2667, minus therapeutic aromatherapy (194), therapeutic massage therapy (126), and therapeutic reflexology (594), totalling 914].

1.27 Compared to the numbers of conventional-medicine practitioners, this is miniscule, although it should be noted that a few HPCSA-registered conventional-medicine practitioners are also registered as AHPCSA practitioners.

1.28 As mentioned above, practitioners registered with the AHPCSA also order pathology and radiology diagnostic tests.

1.29 Practitioners registered with the AHPCSA may, however, not treat patients in hospitals (i.e. in-patients), and may not refer patients to medical specialists (i.e. specialists registered with the HPCSA).

1.30 Patients and consumers consulting registered allied health professionals tend to be of a South African middle-income grouping utilising the private sector, particularly as the allied health professionals are not, at present, officially incorporated into the public sector as indicated earlier.

1.31 It can be argued that professionals registered with the AHPCSA can contribute meaningfully within the private healthcare system at a Primary Health Care (PHC) level with ambulatory, non- emergency, non-surgical and non-obstetrics patients.

1.32 Although the van den Heever review[2] does not even mention health professionals registered with the AHPCSA, the following paragraphs on page 43 seem particularly pertinent to professionals registered under the AHPCSA:

> "8.60 Although medical schemes pay for a large range of medical benefits, not all benefits are risk- pooled (insured) as not all are consistent with the requirements for insurance to be offered on a sustainable basis. For insurance to be sustainable, the insured benefit should: occur infrequently; have a relatively high cost per occurrence; and should not be available at the discretion of the insured. Although these requirements are satisfied for catastrophic health expenses, many services occur frequently, involve low costs per event, and are initiated at the discretion of the patient. (all underlining added)
>
> "8.61 Medical schemes mitigate this risk by effectively making members self-fund for benefits in this range, with claims exceeding an excess value claimable from a risk-pool. Benefit expenses recoverable from a risk pool-reflect a very different cost trend to those that are technically funded on an out-of-pocket basis. Hospital and specialist costs are almost entirely funded from risk-pools, while medicines, [allied health professionals,] general practitioners (GPs), and dentists are self- funded through medical savings accounts and annual claim limits (which is equivalent to an annual budget)." (all underlining and highlighted insertion added)

[2] Prof Alex van den Heever, REVIEW OF COMPETITION IN THE SOUTH AFRICAN HEALTH SYSTEM, 19 JUNE 2012
http://www.healthinquiry.net/Public%20Documents/Review%20of%20Competition%20in%20the%20South%20African%20Health %20System.pdf
(accessed 24-10-2014)

1.33 Where medical schemes do include allied health professionals services (and products), these are also effectively self-funded or technically funded on an out-of-pocket basis.

1.34 Further in van den Heever's review (pages 86-87) appears the following:

> "18.22 Specialists [allied health professionals] working in the private sector also have very little option but to operate within the prevailing context. They are not really in a position to contract independently with schemes, as their relationships with hospitals are more lucrative and simpler. The relatively small number of specialists exacerbates this problem in general, which structurally reduces the opportunities for alternative contracting arrangements with medical schemes. (all underlining and highlighted insertion added)
>
> "18.23 Specialists [allied health professionals] also purchase equipment, available within their rooms, which permits them to self-refer to services in which they have a financial interest. Although in many instances this can be regarded as a legitimate convenience, distinguishing between a legitimate and inappropriate use of such equipment is next to impossible." (highlighted insertion added)

1.35 The relatively small number of allied health professionals certainly "structurally reduces . . . opportunities for alternative contracting arrangements with medical schemes."

1.36 On page 89 van den Heever states:

> "**Market structure interventions that could improve competition**
>
> "18.26 The gatekeeper role of the GP [or allied health professional] could be assured through a statutory requirement that medical schemes cannot reimburse any medical expense of a patient where they've bypassed the GP [or allied health professional]." (Bold in original, highlighted insertions added).

1.37 Allied health professionals should also play their part as gatekeepers at the primary health care level.

1.38 On page 100, van den Heever states:

> **"Doctors (GPs and specialists)**
>
> "20.7 GPs [allied health professionals] and specialists have inverted their roles in the South African health system with the former no longer playing the pivotal gatekeeper role. Specialists are now often seeing patients that should be seen and treated by a GP [allied health professionals] with implications for cost and hospital admissions. GPs [allied health professional] can in fact play a central role in directing patients to care based on quality and cost-effectiveness criteria. The GP [allied health professional] is able to provide information which patients [otherwise] find difficult to process including where best to refer. Re-directing the role of

the GP [allied health professional] in private care is central to shifting from inefficient patient-directed to purchaser-directed care. Provided GPs [allied health professionals] are not conflicted, have access to relevant information (on cost and quality), they can generate competition between specialist practices and hospitals [between allied health professionals]. However, doctors [allied health practitioners] are regulated through outdated "ethical" rules, which prevent the publication of any information relevant to competition.[???] These rules are also interpreted to prohibit the employment of doctors [allied health professionals] by health facilities of any kind. Despite this, doctors [allied health professionals] are free to enter into conflicted relationships of all forms with facilities and product suppliers. Doctors [allied health professionals] also collude horizontally in the determination of medical scheme tariffs, out-of-pocket charges, and negotiated medical scheme contracts." (underlining, deletion, highlighted insertions and question marks insertion, all added.)

1.39 There is a substantive role for allied health care practitioners to play, as gatekeepers and who are able to provide a quality health care, especially in the preventative medicine and lifestyle disease.

1.40 The pertinent and commonly asked question, namely whether there are any evidence-based studies that complementary medicines work, is ubiquitous. The gold standard is Randomized Controlled Trials, with double blind placebo controlled studies.

1.41 The nature of treatment on patient individualization and not disease-oriented therapy often proves problematic to assess complementary medicines using these specific methodologies. The biggest obstacle to research is funding. With complementary medicines most products are naturally occurring and there is no novel chemical that can be patented. Without the potential of a patent, return on investment, there is little funding available to conduct large-scale trials.

1.42 Relative to the Indian model again, the AYUSH disciplines have a Central Council for Research for each discipline, which is funded by the state.

1.43 The Central Council for Research in Homeopathy (CCRH), which may be accessed at www.ccrhindia.org conducts research, reviews articles and publications on homeopathic therapeutics and is published on an ongoing basis.

1.44 Much published research may be accessed at www.ccrhindia.org. Homeopathic medicine treats almost 200 million people in India, almost four times the population of South Africa. It would be relevant and important that we have collaboration at an inter-ministerial and inter-governmental level with our BRICS partner.

1.45 To conclude, the mainstream-medical model is the prevailing model as there is access to facility, funding, state support and utilization. It continues to provide

the majority of research output. As such, it has become the dominant model. Lack of access and marginalisation by the private and public health sectors will lead to other other systems of medicine remaining under-utilized, poorly understood and will not be used for the benefit of our citizens who face a quintuple burden of disease.

1.46 If these professions are given the opportunity to be part of the healthcare system of South Africa, they will improve the healthcare of our citizens as they have done for centuries in some systems and thousands of years for other systems.

2. CONSULTING ROOMS

2.1 The AHPCSA is precluded from sharing premises with any person registered under the HPCSA, by HPCSA legal precepts, although AHPCSA Regulations (Section 54(5), Regulations No. R.127 of 12 February 2001) permit any AHPCSA practitioner of therapist to share consulting rooms with any other person registered with any other statutory health council.

2.2 This effectively precludes any competitive practices from being established, specifically within medical facilities. This impacts on fair practice in the private sector and is, moreover, used as a mechanism to exclude AHPCSA practitioners and therapists in the public sector. In terms of equalisation of status and accessibility of the professions to the public and to ensure the best multidisciplinary approach in healthcare, this is anti-competitive, if not dubious constitutionally.

3. PERSONS PRACTISING AHPCSA PROFESSIONS UNLAWFULLY

3.1 The question of persons practising allied health professions for gain, without registration with the AHPCSA, has been raised consistently over the past decade with the NDoH, and latterly also with the Forum of Statutory Health Councils.

3.2 The AHPCSA is not empowered by the Act to redress this fundamental position which is to the detriment of registered practitioners and therapists and impacts negatively on their practices, since legal jurisdiction lies with the law enforcement authorities.

3.3 There exists little understanding, or a fundamental unwillingness, on the part of law enforcement agencies to initiate proceedings against such persons.

3.4 This position is to the fundamental detriment of the health of the public, in that unqualified persons are receiving persons, making diagnoses for which they have no substantive education and training and administering, prescribing and selling medicines with no enforcement this criminal action.

4. PERSONS/INSTITUTIONS OFFERING EDUCATION AND TRAINING UNLAWFULLY

4.1 The question of persons/institutions offering education and training without registration of the qualification with the South African Qualifications Authority, registration with the Department of Higher Education and Training (DHET), accreditation with the Council on Higher Education or the Quality Council for Trades and Occupations, and with the approval of the AHPCSA, (Section 16A of the Act) has been raised consistently with the NDoH and the DHET and latterly also with the Forum of Statutory Health Councils.

4.2 The AHPCSA is not empowered by the Act to redress this fundamental position which is to the detriment of registered practitioners and therapists and impacts negatively on their practices since persons so trained are entering AHPCSA professions with education and training which does not comply with minimum statutory requirements.

4.3 No action on the part of the NDoH or the DHET has been forthcoming to date to engage with the law enforcement agencies to initiate proceedings against such persons/institutions.

4.4 This position is to the fundamental detriment of the health of the public in that persons with such sub-standard education are engaged in offering health services, compounded with no enforcement this criminal action.

4.5 This matter is to the fundamental detriment particularly in the professions of Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology, where persons practising these therapies illegally make any manner of health and wellness claims, which AHPCSA therapists are disallowed by legislative precepts.

5. EDUCATION AND TRAINING

5.1 Education and training in diagnostic allied health professions meet the standards of conventional-medicine practitioners, with the exception of surgery which is not integral to allied health professions; in the case of the therapies, therapists are trained in anatomy, physiology, pathophysiology and profession-specific fields.

5.2 Education and training in allied health profession does not receive due recognition in either the public or governmental domain.

5.3 Public institutions of education and training have the capacity to offer bursaries, student loans and fees are generally lower than for private institutions of education and training.

5.4 This impacts negatively on the education and training for Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology and private providers of education and training are closing their establishments due to lack of enrolment being unable to offer education bridging-finance, but also due to the fact that, in the public mind, allied health professions qualifications are in some way inferior.

5.5 Since medical aids reimburse a conventional-medicine practitioner, but not an allied health professions practitioner as defined in the Act, this adds fundamentally to the perception that allied health professions are inferior.

6. MARKETING

6.1 The AHPCSA is limited, as are other statutory health councils, by registration fees from registered persons.

6.2 The AHPCSA has seen considerable attrition in the Registers: Therapeutic Aromatherapy, Therapeutic Massage Therapy and Therapeutic Reflexology, due to various factors and particularly those mentioned above, with a profound effect on its income annually.

6.3 This has resulted in a lack of availability of funding to engage on a marketing campaign to inform the public on fundamental questions relating to allied health professions, such as the question of persons practising illegally with sub-standard education and other issues which are detrimental to the health of the public.

6.4 The question of recognition of the AHPCSA and an 'Organ of State', as defined in the Constitution and which requirements it meets, was not received favourably by the former Deputy Minister of Health, Dr Ramokgopa.

7. NATIONAL HEALTH INSURANCE (NHI) AND NATIONAL HEALTH REFERENCE PRICING LIST (NHRPL)

7.1 The AHPCSA has submitted a comprehensive submission regarding the NHI and does not yet have any indication from the NDoH and whether allied health professions will be admitted to the NHI.

7.2 As indicated in paragraph 1 above, professionals registered with the AHPCSA can contribute meaningfully within the private healthcare system at a Primary Health Care level with ambulatory, non- emergency, non-surgical and non-obstetrics patients.

7.3 Lack of acceptance in the NHI is seen as fundamentally detrimental to all allied health professions and will contribute fundamentally to further attrition in the numbers of person registered with the AHPCSA and a possible eventual demise in certain allied health professions.

7.4 There has been no NHRPL survey since 2007, which negatively affects the ability of practitioners and therapists to offer medical aid respite to patients and is a fundamental question, as indicated above, in certain professions being accepted by medical aids.

8. CONCLUSION

The AHPCSA would like to thank the Consumer Commission for the opportunity to raise issues of concern and to indicate that it is willing to clarify further any of the points raised in this submission, should the Competition Commission require further clarification.