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Competition Commission
Health Market Inquiry
Trevenna Campus,
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Sunnyside
PRETORIA
0002

5 March 2015

ATTENTION: Mr. Clint Oellermann

Via Email: submissions@healthinquiry.net

Dear Sirs,

WRITTEN SUBMISSION BY THE INDEPENDENT PRACTITIONERS ASSOCIATION FOUNDATION IN TERMS OF SUPPLEMENTARY GUIDELINES NO. 1 – HEALTH MARKET INQUIRY

1. The Independent Practitioners Association Foundation ("IPAF") made a submission to the Health Market Inquiry and we will refer to that submission in this supplementary submission to avoid duplication.

2. **Submission by Emerging Market Healthcare *(reproduced in red italics)***

"*This has at times led to disrespect for the professional autonomy of providers at a coalface level and the organized medico political groupings like an IPA that they joined and formed during the Apartheid years.*

Existing relationships and an 'Old Boys Club' mentality has presided over the private healthcare industry creating power dynamics and distortions of competition at the general practitioner (GP) level. This has led to arbitrary advantage of one provider over another and one organization over another.

As such, groups with an independent mind set and who have raised the challenges of professional autonomy and choice as well as request the shift to a more simplistic and less stringent means of contracting and peer review have become marginalized by the simple point of 'not fitting in' with either the populist approach or surrendering their value drivers to become part of the club."

IPAF response (in black text)

The IPAF is a non-racial fully integrated network company established in 2007 consisting mainly of 3 national general practitioner networks ASAIPA, SPNet and SAMCC. The IPAF has an executive committee representative of each IPA grouping in IPAF. The original Board comprises office bearers, elected by the constituent IPA's, for a period of 3 years. Thereafter these office bearers are eligible for reappointment. The current office bearers are Prof. Morgan Chetty (Chairperson), Dr Tony Behrman (Chief Executive Officer), Dr Elijah Nkosi, Dr Mukesh Govind, Dr Anton Prinsloo, Dr Dennis Dyer, and Henru Kruger.

IPAF is a non-profit network management company which also provides peer profiling and review services to Funders.

Membership of all three constituent networks is voluntary and general practitioners ("GP's") belonging to these networks can either join through the aforementioned networks; through other smaller network companies or join IPAF directly as long as they agree to accept IPAF's peer review and profiling system.

EMC used to be a member of IPAF but withdrew a number of years ago for reasons that they wanted to change the corporate structure of IPAF from a non-profit company (previously referred to as a section 21 Company) to a Co-operative. They were also desirous of selling their IT services for peer profiling and review to the IPAF. Neither suggestion was accepted by the IPAF Board of Directors and EMC resigned and withdrew from the IPAF.

. EMC's Dr Naidoo, has since informally requested on at least 2 occasions to re-join the IPAF Board of directors but insisted on representation on IPAF's executive committee which could not be agreed to as IPAF has an elected executive who are currently serving their terms as board members.

3. *"Whilst the Medical Schemes Act has purported community rating and cross subsidization, the DSP guidelines have limited choice, access and created*

undesirable ethical dilemmas for both affected patients and providers. The DSP contracting model, especially at a GP level has become a 'cherry picking' exercise especially in the market of low cost options rather than following a model of 'ready, willing and able' provider participation. Effectively these distortions have led to longstanding familial relationships with their chosen practitioners stopping. The poor patient especially in the geographic areas of townships can least afford travel and other indirect costs of seeking healthcare service."

The Managed Care regulations embodied in the Medical Schemes Act, create the establishment of Designated Service Providers (DSP's).

Today many Funders use Designated Service Provider Networks ("DSP" networks) in an attempt to curb rising provider costs.

DSP networks provide the Funder with an opportunity to direct their patient members to those service providers with whom they have contracted at a rate offered unilaterally by the a Funders and accepted by the providers, usually in return for quality enhancement and reduction on downstream costs, as well as in return for a promise not to balance bill the patient.[1] This principle is embodied in the contracts IPAF has concluded with Funders where it provides network services to such Funder. So essentially DSP networks are a form of financial risk-sharing between the Funder and the provider **whereby the provider or physician contracted by the Funder agrees to be remunerated in accordance with the fee set by the Funder regardless of the actual duration of the patient's visit, for example to a GP.**

IPAF has not concluded any contract containing terms with Funders, prohibiting or preventing any other GP network or any other GP who is not a member of IPAF to become a DSP network provider to the Fund. **The provider has to, however agree to the Funder's terms and conditions and to submit to some form of peer review and profiling (not necessarily that of IPAF although it is available as a service to non-IPAF members as well).**

[1] Balance billing is the practice whereby a physician claims the medical aid contribution for services rendered from the medical scheme but requires the patient to pay the difference between the medical scheme rate and the price actually charged by the physician.

There is therefore no question of excluding any GP from a DSP network as long as the GP adheres to the concomitant terms and conditions. It is very much in the interest of patients especially in poorer areas not to be balance billed when seeing their GP and to have their overall medical cost reduced due to the benefits of preventative care (see paragraph 7 and 7.1 of the IPAF submission for a full explanation of how the IPAF peer profiling and review system seeks to ensure better quality outcomes for patients at a lower cost).

4. *"As an organization we have continuously cautioned about the issues of price setting, and anti-competitive and possible coordinated conduct amongst the organized IPA groups and practitioners. Notwithstanding power during negotiations with medical schemes and administrators are very much dominated by the presiding medical scheme or administrator, which is in a position of oligopolistic control over the contracted medical scheme."*

The IPAF does not negotiate or receive any mandate from its GP members to negotiate any DSP network fees or any other GP consultation rates or fees with Funders on behalf of its members. Since the 2004 fine imposed on SAMA for price fixing, its members including GP's were no longer allowed to collectively bargain with Funders. The IPAF and its members abide by this decision.

Certain Funders have, however, elected to contract with IPAF and its registered members, as their DSP network providers, because IPAF represents ease of access to a reliable cohort of doctors from the IPAF and because of the transparent and reliable peer profiling system and resultant peer review process run by IPAF and Insight. The remuneration rate is entirely at the discretion of the Funder and it **is up to the individual GP to elect whether or not to accept the rate the Funder is offering.** The IPAF does not negotiate these rates with Funders in any form or manner.

The Council for Medical Schemes announces an annual recommended increase and in 2014 recommended that the increase to providers be limited to 6%.

Following on this circular medical schemes and administrators announced the following increases in tariffs paid to GP's for 2014:

1. Discovery Health - 6.0%
2. Momentum Health - 5.5%
3. Bonitas – 6.0%
4. Medscheme – 6.0% to 6.6%
5. Metropolitan Health 6.0% to 6.6%
6. GEMS – 3.8%

(Although GEMS announced a 6.0% increase for 2015, this would only apply to contracted paediatricians and gynaecologists; whereas the bulk of codes reflect an average increase of only 3.8% - calculated HealthMan).

7. Profmed - 6.5%
8. Liberty Health Medical Scheme – 6.0%
9. Medshield - 6.0%
10. Medihelp - 6.0%
11. Bestmed - 6.6%

5. *"We raise here the example of Layered contracting challenges, which has focused on self- serving representation in terms of IPA affiliation and central peer review mechanisms creating arbitrary competitive advantage (including access, choice and supersession) of IPA doctor over non IPA doctor as well as favour certain IPA organisations over another (example: IPA Foundation) – whilst entity is purportedly non for profit, the layer creates added costs and entrenches the anti- competitive environment amongst existing IPA groupings at the coalface. --- Affected medical schemes and/or their options in the above anti-competitive arrangements include Bankmed (where the challenge initially occurred…see Addendum 3, Bestmed, Medihelp, Liberty) Reference: Addendum 3 (a), (b), (c) --- Bankmed /IPAF Complaint to the CMSA."*

We refer the Panel of Inquiry to point 3 of this supplementary submission. There can be no question of an arbitrary advantage as any GP can become a DSP network provider subject to agreeing to the Funders terms and conditions. This is not an arbitrary advantage but based on a financial risk sharing model and agreeing to a system of peer review and profiling. Peer review and profiling has proven to lower costs to schemes while improving patient outcomes.[2] The

[2] See Annexures IPAF 2 and 3 hereto which illustrates the financial impact of introducing a DSP network while improving health outcomes for patients by focus on preventative care.

patient can still exercise complete freedom of choice in terms of which GP to consult with, so access to GP's is in no way restricted , although there may be a financial disincentive to the patient in terms of balance billing if such GP is not a contracted DSP.

Supersession is a term used to describe the action whereby a physician assumes the care for a patient without due regard for the current physician responsible for the care of the patient. The reason for this ethical rule[3] is to protect the patient against unscrupulous practitioners who are usurping the care of the patient for financial reasons. There is, as far as IPAF is aware, no record of any complaint brought against any of its members by the HPCSA for supersession due to being a contracted network DSP to IPAF. The primary aim of peer profiling and review through a network of doctors is in fact to provide better care to patients at less cost.

6. **Submission by SAMA (reproduced in green italics)**

"Notwithstanding the fact that Regulation 8 to the MSA provides that medical schemes must "pay in full" for the costs of the diagnosis, treatment and care of PMB conditions, the vast majority of schemes offer to pay for such PMB conditions "according to scheme rate" and not "in full" as prescribed by the Regulations. This "scheme rate" is determined by the scheme arising from negotiations with, amongst others IPA groupings, hospital groups etc.

As repeated earlier neither IPAF nor its member IPA's negotiate scheme rates or any rates for PMB conditions. These are unilaterally set by schemes.

7. ***"3.4 Preferred Provider "Network" Contracts***

These contracts usually require doctors to strictly adhere to treatment protocols and formularies. Many such contracts are negotiated and agreed upon by Independent Practitioner Associations and preferential rates are paid to members of these IPA's whereas non-members qualify for lower reimbursement levels.

[3] Which is an ethical rule of the Health Professions Council of South Africa.

The Designated Service Provider (DSP) and Preferred Provider (PP) contracts are negotiated by Independent Practitioner Associations (IPAs) that in turn receive a fee for every doctor who signs up. As a result preferential rates are paid to members of these IPAs."

"3.5 IPA's and Management Companies

Despite the fact that SAMA may not and does not determine a tariff guideline on behalf of its members, other physician groupings such as the Independent Practitioner Organisations, Management Companies and Specialist Societies continue to do so. The Designated Service Provider (DSP) and Preferred Provider (PP) contracts are negotiated by Independent Practitioner Associations (IPAs). As a result preferential rates are paid to members of these IPAs.

They disguise their actions by claiming to be price takers, and that they do not actually negotiate tariffs with medical schemes, despite evidence to the contrary.

While we have made mention of certain groups (Independent Practitioner Associations) that openly negotiate preferential reimbursement for their members, SAMA consistently adheres to its undertakings and does not negotiate fees with medical Schemes."

IPAF provides a contracted DSP network to numerous Funders but as explained in paragraph 4 of this supplementary submission does not negotiate rates.

Bankmed has for example contracted approximately 75% of its GP DSP network from IPAF members and 25% are non-IPAF members. These **DSP network providers earn exactly the same** remuneration from **Bankmed regardless of whether they are IPAF members or not as** long as they agree to comply with Bankmed's terms and conditions and submit to peer profiling and review.

The IPAF's GP profiling and peer review system assures Funders of a transparent clinical quality management and review system which monitors GP utilisation and clinical outcomes and represents inherent value to such Funders. This is a proven outcome of IPAF's quality management system (please refer to annexure 2) hence **some** Funders are willing to pay IPAF member GP's more

than non-IPAF members. To re-iterate, the IPAF does not negotiate any DSP network or contracted GP rates with Funders.

Once contracted as a DSP network provider, a GP may earn a performance-based re-imbursement fee depending on how they score according to that particular scheme's profiling system. If they score well consistently they may fall in an upper category allowing such DSP network provider to earn an augmented **performance based re-imbursement fee.** Each Funder has its own performance based re-imbursement fee that it is willing to pay and this is agreed directly between the Funder and DSP network provider when the latter accedes to the Funder's contracting terms and conditions. Some Funders don't have performance based re-imbursement fees. The IPAF does not set or influence performance-based re-imbursement (PBR) incentive schemes in any form or manner with GP's or Funders.

Where the IPAF (as a business) provides peer review and profiling services to Funders, it does charge the scheme for this service. This is a fee charged by the IPAF to the Funder directly and paid to the IPAF in part for:

1) the development of the process and;
2) the maintenance of the IT system and network;
3) running of profiling services provided by our actuaries Insight and
4) the fees paid to the peer reviewers employed by IPAF.

The quantum of the fees paid by the Funders to IPAF is based upon the number of principle members in the scheme per month.

8. ***"Contracts negotiated by Third Party groups***

Further, many such contracts are negotiated and agreed upon by Independent Practitioner Associations and preferential rates are paid to members of these IPA's whereas non-members qualify for lower reimbursement levels.

Non IPA members furthermore receive lower reimbursement rates from the scheme, even if they sign exactly the same contracts. Doctors who do not sign the contracts at all, receive an even lower fee, which in effect becomes an inducement for doctors to join the IPAs and sign the contracts. The result is that

the IPA leadership impose central control over primary healthcare provision by facilitating these contracts under the guise of peer management in order to advance their own vested interests and then use their market dominance to force non-IPA doctors to join their IPA. These types of arrangements therefore have the effect of adding numerous layers of non-healthcare costs and exclude independent doctors without any healthcare benefit to the patient."

These allegations are very similar to that of EMC and please refer to IPAF's answer in paragraph 5. Given the proven reduction of healthcare costs and improvement of healthcare outcomes to patients[4] due to the introduction of peer review and profiling SAMA is incorrect in its assertion that IPAF's peer profiling and review adds a cost layer with no benefit to patients

There is absolutely no question of IPAF forcing GP's to join its network and as mentioned at the outset IPAF is a non-profit company. No Funder excludes any GP from becoming a network DSP due to such Funder also contracting with IPAF members.

Yours sincerely,

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[4] See annexures 2 and 3