national · pathology · group

SPECIAL INTEREST GROUP OF THE SOUTH AFRICAN MEDICAL ASSOCIATION

Competition Commission: Inquiry into the Private Healthcare Sector
The Panel Chairperson
Chief Justice Ngcobo
c/o Inquiry Director
Mr Clint Oellermann

Sent by e-mail: clinto@healthinquiry.net

REPLY TO SUBMISSIONS:

NPG ON BEHALF OF INDUSTRY, OF WHICH MEMBERS HAVE SUBMITTED COMMENTS

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1. LEGAL BASIS FOR THIS REPLY

The National Pathology Group - NPG did not make a submission to the Competition Commission Inquiry Panel in October 2014, due to concerns of collusive behaviour.

We have, however, found that specific allegations are made in relation to the profession of pathology and deem it of the utmost importance that the Commission and the Panel, is in possession of accurate information in relation to the profession. We are obliged to make this submission, as recommendations of the Panel will impact on professional- and industry-wide matters and could have implications for our profession and employees.

We are not privy to the individual submissions of our members. They will deal with all other matters as they deem fit.

We are therefore making this submission in **exercising our right to reply** in relation to professional matters, as well as to **inform the Panel** on matters pertaining to our profession.

2. INTRODUCTION: What is the NPG?

" ..... as is your pathology, so is your medicine."

Sir William Osler (1849 – 1919)

The National Pathology Group is the official subgroup for pathology of the South African Medical Association (SAMA). Membership is open to pathologists who are registered with the Health Professions Council of South Africa (HPCSA) and who are members of the SAMA. It has approximately 255 pathologist members of all disciplines in pathology who are widely distributed in South Africa.

Appropriate pathology testing influences up to 70% of diagnosis and consequently appropriate therapy for patients. This contributes significantly to cost-effective patient care. The discipline of pathology is critical for medical care of all patients.

Bacterial identification obtained from hospitalised patient specimens is used widely in infection control in hospitals and advice given to clinicians for appropriate, cost-effective antibiotic use.

Data extracted from laboratory results are used more broadly than the individual patient's case. Pathologists report the diagnoses of malignancies to the National Cancer Registry as legally required. This registry compiles reports on the incidence of malignancies in South Africa. The data is widely used in healthcare planning.

The group promotes best practice standards and its members adhere to a Code of Ethical Conduct. Its objective is to inform medical practitioners about on-going developments in pathology and to update practitioners about these developments. In so doing it promotes accurate diagnosis and quality care of patients. This results in appropriate and cost-effective therapy.

The NPG members have large numbers of centralized and peripheral branch laboratories and blood collection depots throughout South Africa and perform about 200 000 individual tests daily. Through courier-services it reaches many of the remote and under-services areas, where the establishment of laboratories or depots are not feasible. The test range extends over all pathology disciplines and includes an extensive range of chemistry and haematology testing and also the diagnosis of infectious diseases like tuberculosis and HIV, as well as histopathology and cytology. Its services align with the prioritization of the National Department of Health to be responsive to the quadruple burden of disease (viz. HIV/Aids and TB, Maternal and Child Health, Non-Communicable Diseases and Injuries / violence).

Quality and coverage: contribution of NPG to access to laboratory services

Accreditation	90% of all existing facilities
Courier km's travelled per month	3,431,000
Tests done per day	200,000+
Number of patients serviced per day	53,000+
Rural penetration of services	28% of all tests

Members employ more than 10 000 staff members and a large number of these are professional, pathologists, medical technologists and technicians and nursing sisters. Members are also actively involved in the tuition of pathology registrars and lecturing of medical students.

Professionals active in- and employed by NPG members	
Total number of employees	10,738 (excluding pathologists)
Total number of pathologists	255 (including part-time)
Breakdown of employees:	
Laboratory technologists	1560 (+-)
Laboratory technicians	868
Phlebotomy technicians	172
Medical Scientists	51 (+-)
Nursing Sisters	2390 (+-)

Approximately 90% of our member laboratories are accredited by SANAS (South African National Accreditation System of the Department of Trade and Industry based on the International ISO Standard.

3. RIGHT OF REPLY TO SUBMISSIONS MADE BY VERIRAD

In our comment below we will use the same headings as used by Verirad.

3.1 "Increases in expenditure since 2002…"

The information we present hereafter is taken from the most recent Council for Medical Schemes' report and is corrected for membership numbers. The graph used by Mr Adams has not been corrected for inflation and consequently presents an incorrect picture.

The National Pathology Group retained the services of Lifechoice/Prognosys to compile a 5-year review based on the recent report of the Council for Medical Schemes published in the latter part of 2014. (Attached hereto as Annexure A)

The most significant findings of this review are:

- Over the last 5 years, pathology utilisation has increased more rapidly than utilisation of other services (24% increase).
- The utilisation increase has been the main driver behind an observed increase in pathology costs.
- When correcting for increases in utilisation, it is found that pathology cost per utilisation has increased by 7.9% in real terms since 2008.
- This increase is less than the equivalent increase in other medical specialists' costs, hospital costs and radiologists' costs.
- Increased pathology utilisation should be expected given the worsening risk profile in schemes and the increase in the prevalence of certain conditions (e.g. HIV, Hypertension, Diabetes etc.) being reported by schemes.

It is important to understand that pathology is a referral specialty. This means that pathologist themselves do not drive utilisation. Tests are requested by clinicians (e.g. specialist physicians, cardiologists, general practitioners, etc.) and referred to the laboratory. The laboratory does not generate test requests at its own behest.

The reasons for increased utilisation insofar as it relates to burden of disease, adverse selection, and incomplete medical schemes legislative reforms and other demographic factors have been thoroughly canvassed by other stakeholders and will not be repeated here. Medscheme calculates that its 'above inflation' premium increases are only to a very small degree of 1.1 percentage points, attributable to new technology, utilisation and other aspects. The impact of demographics and patient behavior (e.g. buy-downs) is far more pronounced at 4.2 percentage points, than utilisation. Metropolitan, who only administer closed schemes, report pathology tariff increases of less than CPI. To reiterate, pathologists do not control utilisation.

Figure 1 reflects the cumulative growth in real benefits paid per annum and Figure 2 indicates the cumulative growth in utilisation since 2008.

It is important to note that the increased utilisation in pathology reflects the same increases as present in those of medical specialists, radiologists and hospitals.

Figure 1: Cumulative Growth in Real Benefits Paid Per Beneficiary Per Annum Since 2008

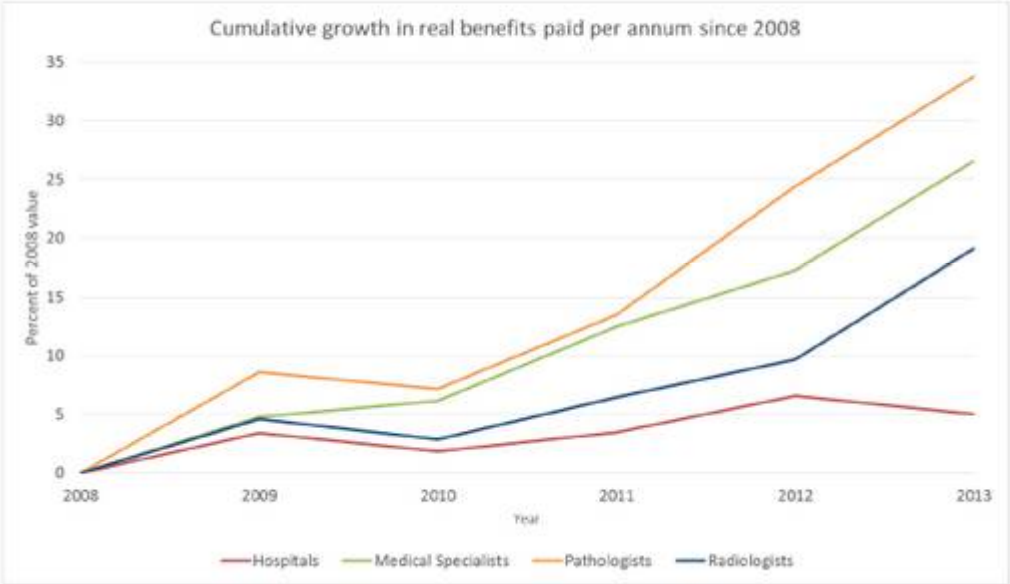


Figure 2: Cumulative Growth in Utilisation Since 2008

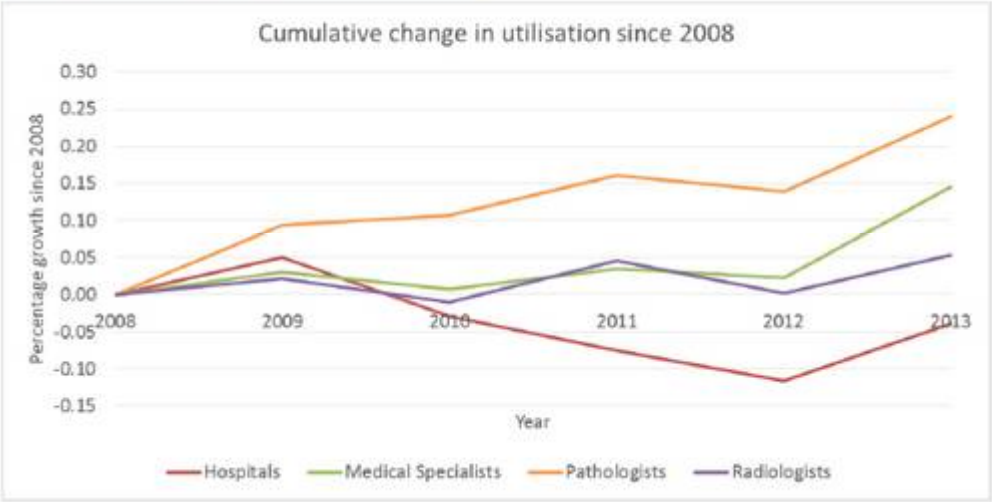
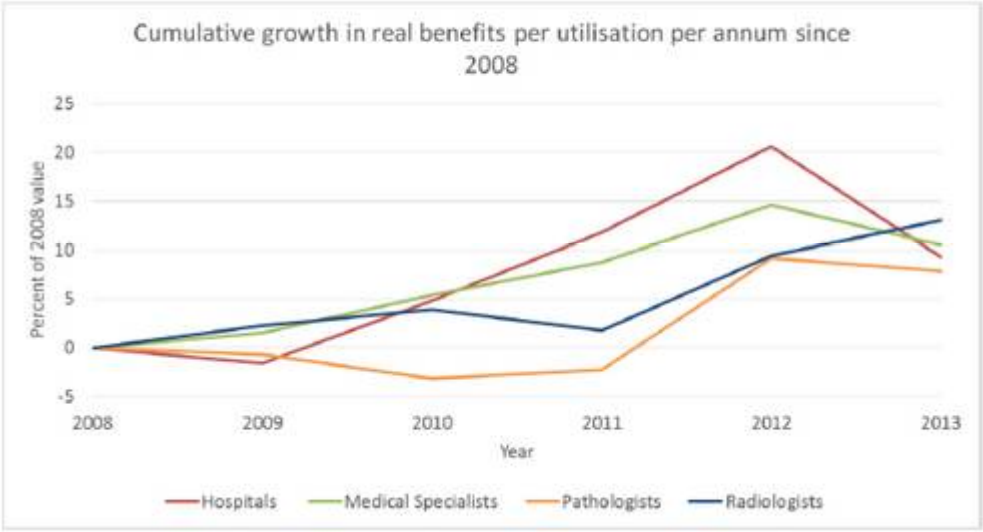


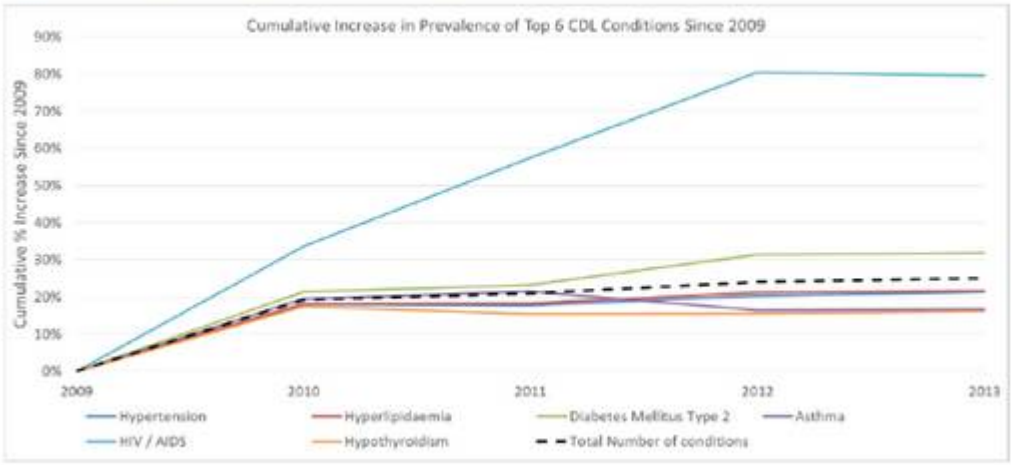
Figure 3: Cumulative Growth in Real Benefits per Utilisation Since 2008



All the above should be carefully interpreted on the basis of the changing disease profile in South Africa.

Figure 4 indicates the changing disease and age profile of medical schemes. Undoubtedly this has a significant impact on the overall costs by medical schemes and more specifically pathology expenditure as this is so critical in the diagnosis and appropriate care of patients.

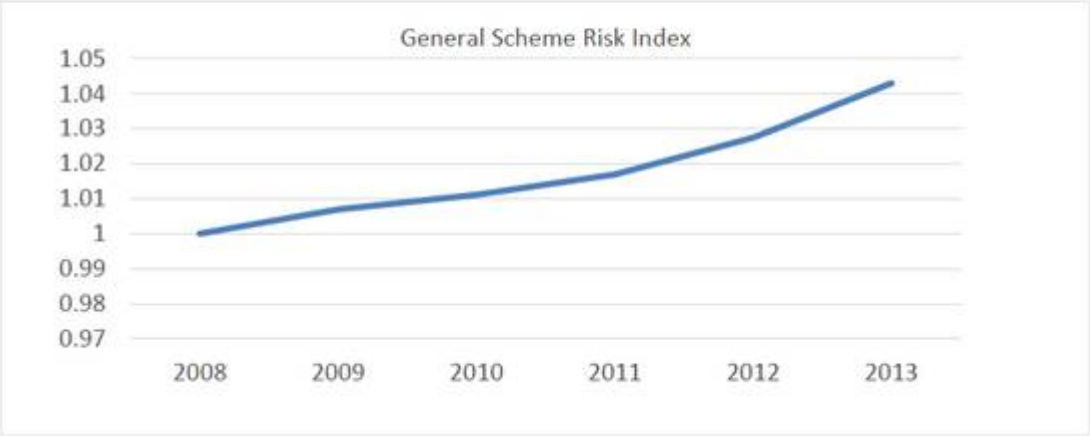
Figure 4: Cumulative Increase in Chronic Disease Prevalence



Pathology utilisation will be impacted by this. In addition, pathology is, unlike other specialities, not insulated from any of the communicable or non-communicable disease burdens this country is facing. An orthopaedic surgeon will, for example, not deal with oncology, HIV, lung or cardio-vascular problems. The pathologist does and will.

Increasing age and more specifically the changes in membership in age bands, will impact pathology costs. The General Scheme Risk Index (GSRI) is an Index compiled by Prognosys which corrects for the cost-risk profile of beneficiaries depending on age and gender, by predicting the likelihood of chronic disease and multiplying this with average cost of such disease. This index in figure 5 shows the clear effect that changing age has on scheme risk which will impact pathology costs. The GSRI of the industry has worsened by over 4% since 2008.

Figure 5: General Scheme Risk Index (GSRI) Trend



The view presented by Mr Adams of the cumulative changes in medical expenditure does not consider the complexities of the current private healthcare sector and is therefore an over-simplification of the matter at hand.

3.2 "Request form issues"

This was not only raised by Verirad, but also by many other stakeholders. In order to understand this matter and the Seedat Commission to which stakeholders such as the BHF refer, we provide the following information:

In 2006 the HPCSA convened a task team, mandated by its Committee for Undesirable Business Practice, to investigate aspects of pathology, amongst others, the use of laboratory request forms. This investigation was undertaken under Prof YK Seedat. The NPG made many submissions to this sub-committee. Eventually a draft proposal was produced and tabled at the Medical and Dental Professions Board (MDPB).

The NPG made extensive comments to the MDPB and final comment was submitted on 25 November 2013 to the Board. A process of public inquiry was to follow. Notwithstanding many enquiries as to the status of the public inquiry there has been no progress. It is our understanding that the public inquiry has not commenced.

The NPG instituted its own process to deal with this issue, given the importance and the lack of progress by the MDPB of the HPCSA.

In the first quarter of 2011 the National Pathology Group convened a meeting with a number of the large medical schemes in an attempt at designing a laboratory request form which was appropriate to be used by the general practitioner. Many of the schemes / administrators raising this issue were part of this meeting. Practitioners often find laboratory request forms confusing and this was an honest attempt at cost containment and simplification of the generally used laboratory request form for the average practitioner.

As a result of these consultations, the tests and profile groups which appear on the request form were reduced and simplified and rationalised to reflect the pathology needs profile of the average patient seen by a general practitioner. Practitioners are always entitled to add additional tests or make changes to the form, using handwritten requests, although there is concern about the possible errors which could arise.

These request forms were agreed to by all the participants and have been widely distributed by all laboratories involved as examples of how a simplified restricted form should look. The choice of the request form to be used remains with the practitioner as this is the person who is involved with the patient care and is most appropriately placed to make this decision. Laboratories have no influence over the use of these request forms by practitioners.

The request form has an appropriate space for the patient and the doctor to sign confirming the request and the patient's permission for this to be done. Unfortunately there is sometimes difficulty with these signatures as tests may be requested telephonically or patients may be in hospital. The requesting may be done at the behest of the practitioner by a nursing sister or ward administrator.

The NPG and its individual members remain committed to interaction on this matter and are disappointed that matters are raised to the Panel, without there having been any approach to the NPG on this, since the 2011-interactions. This in itself is perhaps telling of the, in our view unnecessary, animosity between many stakeholders in the private healthcare sector.

3.3 "The fact that the National Pathology group published a guideline to testing and Billing which is anti-competitive"

The National Pathology Group does indeed publish a guideline for coding, but this does not include any prices, price recommendations or even RVU's. The National Pathology Group is an official sub-group of the South African Medical Association and refers to the SAMA Medical Doctor's Coding Manual (MDCM).

Perhaps the most significant misunderstanding in relation to this statement relates to the purpose and function of a coding system. A coding system is a specific nomenclature linked to professional actions, which are accepted by the profession as recording actions within the specific professional group's scope of practice. For example:

3755 Full blood count (*explanatory comment: test for anaemia or leukaemia or infection)*

4171 Urea and electrolytes ((*explanatory comment: test for kidney function)*

LIPOGRAM: (4025) (*explanatory comment: test for blood fats)*

1 Total Cholesterol
2 HDL-Cholesterol
3 LDL-Cholesterol
4 Triglycerides

Note: the test number 4025 has a number of tests included. The tests are also available for individual ordering by the doctor. When done in combination laboratories charge less than the combined total when tests are done individually. This reduces the cost).

The codes are from the SAMA Doctors Medical Coding Manual (DMCM) and the numbers and descriptors specify the correct procedure to be done and the content of the procedure/s. This information is transmitted to the medical scheme administrator to ensure clarity of the test/s done. Payment is determined by individual negotiations between the individual laboratory practice and the scheme. No RVU's (relative value units) appear in the NPG's Guide to coding at all.

The doctor referring the patient for testing knows exactly which tests will be done. Referring doctors have lists of tests that are or are not included.

Whether a profession can, or cannot undertake a specific action depends on their skills and professional training, as well as whether the action is recognised as within the scope of that particular profession.

The guideline attempts to guide clinicians with the appropriate testing to be done in specific conditions, which is *par excellence* a professional matter. This guide was compiled with the assistance of respected academic clinicians within the various disciplines and is periodically updated to reflect current practice. (Guidelines attached as Annexure B and C.)

3.4 "The labs use Employees of Hospital groups to do POC tests that the labs all charge specialist rates"

Point of Care Testing is a critical part of appropriate patient care and improves diagnosis and therapy. Individual firms will reply in relation to their practice in this regard. However, on a principled basis, it must be noted that the equipment and reagents used in POC (also called "near patient") testing are those supplied by the laboratory. Training, quality control and test reporting and archiving and advice is done by the laboratory.

3.5 "Lack of information in respect of ICD10 codes from all private practice laboratories"

This allegation once again shows a lack of understanding as to how laboratories and pathology functions and fits into the provision of care of patients. The pathologist rarely, if ever, sees a patient. The pathologist receives, from a referring practitioner, a request for specific test and may or may not be provided with an ICD10-code. Often the referring doctor also does not know which code to use as that may be exactly the reason why s/he has requested a test - to obtain a diagnosis. The correct ICD-10 code would therefore often follow, and not precede, a diagnosis.

In general laboratories are dependent on clinicians supplying a suspected ICD-10 code, or if known, the correct ICD10 code or codes (in cases of comorbidities). The codes are submitted to medical schemes.

The clinical laboratory does not frequently make specific diagnoses. Medical schemes require a code prior to processing a claim. Where the referring practitioner has not supplied an ICD-10 code, laboratories have no choice but to use the so-called "generic" ICD10 codes, which are not attached to a specific condition.

Histo-pathologists do make specific diagnoses. These are coded appropriately and this information is available to the medical scheme. Data is also submitted to the National Cancer Registry as is required by regulations published under the National Health Act.

COMMENT ON SUBMISSION BY EMMANUEL DIAGNOSTIC LABORATORIES AND ASSERTIONS AS TO THE ROLE AND SCOPE OF PRACTICE OF PATHOLOGISTS

We understand the allegation to be that pathology could be rendered in the same manner, only cheaper, if one is not using pathologists. This matter was also raised in general in the background paper to the Inquiry. We believe that clarification is required.

These assertions are made in spite of numerous submissions pointing to the dire shortage of specialists, including pathologists. Details are provided by some submissions on the training role of the NHLS, including the reduced numbers of all relevant healthcare professionals in the field of pathology, being trained. The shortage is also recognised in the Human Resources for Health Plans of the National Department of Health.

The scopes of practice of various healthcare professions, including that of pathology and medical technology, are determined by the Health Professions Council of South Africa (HPCSA). Although complementary within a laboratory environment, the one cannot "stand in" for the other. Many different levels of academic qualifications and skills are applicable. Pathologists are under the professional control of the Medical and Dental Professions Board at the HPCSA, whereas Medical Laboratory Technologists have a separate board for Medical Technology within the HPCSA, as do Medical Scientists.

The work of a medical technologist or -scientist cannot become that of a pathologist. Pathologists are qualified medical practitioners who have studied for five to six years. This is followed with internship of one or two years plus another year of community service. Doctors additionally spend another 4 or 5 years training as registrars under supervision at an academic laboratory attached to a university for four or five years before obtaining the specialist qualification as a pathologist. Training to become a pathologist is therefore 10 or more years.

There are various pathology disciplines i.e. anatomical pathology (histo-pathology), microbiology and virology, chemical pathology, haematology and clinical pathology.

Medical microbiologists and virologists identify organisms, either bacteriae or viruses responsible for infection. They advise on appropriate antibiotic or antiviral therapy as the case may be. They also evaluate the immunity of patients to specific conditions, i.e. tuberculosis, HIV and hepatitis and many others.

Chemical pathologists advise on testing of chemical substances in the blood, tissue fluids or urine or cerebro-spinal fluid. These tests could be glucose, cholesterol, immune control mechanisms, and complex endocrine tests for diabetes and adrenal and hormonal deficiencies.

Haematologists study blood cell diseases. They work with problems of blood not clotting or excessive clotting and also leukaemias and anaemias.

Histopathologists make tissue diagnoses of cancers and examine Pap smears for cancers of the cervix. They also examine tissue while the patient is under anaesthetic during surgery to advise the surgeon on appropriate therapy, so called frozen sections.

The role of the pathologist is to oversee and take professional responsibility for a diagnostic pathology laboratory. This includes the technical aspects, quality control and most importantly diagnostic consultation and advice to clinicians. Pathologists are adequately placed to render this service as they are initially trained as general clinicians and understand disease conditions. They are then subsequently trained as pathologists to understand laboratory medicine. Their specialist knowledge allows them to innovate and develop specific tests in response to South African, and African, healthcare needs. This level of skill cannot be replaced by any technician or medical scientist. The pathologist forms a bridge between the clinician and the laboratory and this is where the training, skill and the focus of the pathologist is, as s/he understands the world of clinical practice and general medicine, but also the laboratory world. This is not the case with other persons who may be trained in the field of laboratory medicine only.

Pathologists are ably assisted within the laboratory environment by medical laboratory technologists and technicians who have both a practical and theoretical training at the various Technikon Universities and within the practice concerned. This training takes approximately 4 years. Medical Scientists generally have a Bachelor of Science degree from a university which takes 3 years.

The training (curriculum and skills sets) for these groups therefore differs significantly. Whilst all are involved in laboratory medicine, the academic knowledge, skill-sets and scope of

practice (i.e. what a professional should, or should not be doing as part of his/her profession) as defined by the HPCSA, differs markedly.

In the early 1990's the HPCSA resolved to allow medical technologists and medical scientists to practice privately and independently without the guidance and oversight of a pathologist. The requirement was that the training should be appropriate and that they should be limited in their scope of practice. They are not allowed or trained to make diagnoses at all. They may not make tissue diagnoses (as histopathologists or haematologists do). They focus on the technical aspects of 'doing the tests'. There was an additional requirement that a suitable period of practical experience should ensue before they were able to practice independently. The initial recommendation to require accreditation was never enforced.

The Board also decided that the fees of the Medical Scientists and the Medical Technologists would be less than that of pathologists and we estimate that, generally, this is at about two thirds of the pathologist fee, but this not a controlled or regulated environment.

EMPLOYMENT OF DOCTORS BY HOSPITALS OR MEDICAL SCHEMES

Some submissions have commented on the employment of doctors as a 'solution' to increasing costs. In reference to pathology, suggestions are made to establish pathology laboratories within hospitals and also by medical scheme administrators.

The HPCSA's ethical rules, specifically, Ethical Rules 7(4), 7(5), and 8(1) preclude this. Employment by an 'outside' party results in sharing of fees. This is illegal.

The reason for this is obvious. The doctor becomes beholden to an outside party and there is a very real risk that patient care will be compromised. The hospital and medical scheme administrator pays the doctor and they act for their shareholders, with the very risk of an income stream as the primary objective. The HPCSA's ethical obligation on the caring doctor has the patient as the first responsibility. Split loyalty by the doctor to an 'outside' employer has the very real risk of creating uncertainty and confusion as to which party's set of rules, or to be specific, ethical rules, to follow. Only doctors are legally bound by HPCSA's ethical rules, hospitals and administrators are not. There is a very real risk of pressure on the laboratory to use cheaper and less reliable analytical processes, reagents or tests with the primary focus cost containment as opposed to reliable and quality outcomes. Reduced pathologist numbers will result in diminished specimen / patient involvement and lack of appropriate clinical advice by the pathologist. The laboratory will become a results factory as opposed to being a source of reliable diagnostic information and appropriate patient care.

The parties promoting employment of doctors and establishing pathology service laboratories give no indication why this would be less expensive. They would be exposed to the same costs as the current, existing laboratories. Cost reduction could only happen by reducing the numbers of qualified personnel, i.e. medical technologists and pathologists or compromising on quality.

Inevitably patient care is compromised.

The NPG trusts that the comment above contributes to placing some of the submissions in context.

We are available should any clarity be required.

DR TJAART, D. ERASMUS
PRESIDENT

3 March 2015