SAPPF
SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM

Unit 16, Northcliff Office Park
203 Beyers Naudé Drive
Northcliff, 2115
P O Box 2127, Crest,a 2118
Reg no: 2008/00439/08
Tel: +27 11 340 9000
Fax: +27 11 782 0270
e-mail: info@sappf.co.za

SAPPF responses to select Competition Commission Inquiry Stakeholder Submissions

At its Thursday 5 February 2015 stakeholder information session presented by Chairperson Retired Chief Justice Sandile Ngcobo, the Competition Tribunal announced the publication of all relevant submissions to the Inquiry into Private Health Care. It expressed hope that participants would take the opportunity to "engage and correct" any claims or data presented therein, upon which the Commission may base its future recommendations.

While SAPPF believes in the comprehensiveness of its initial submission, and welcomes the chance to cooperate with the panel and its appointed technicians to clarify and defend its position, we too have waded through the many submissions by our various peers in the industry. Some allegations have been made which we will let slide, some have been dealt with to our satisfaction hitherto, and some demand a response. We welcome the invitation to do so here and trust that we can comply as precisely, succinctly and with the requisite evidence as the Tribunal demands.

We will proceed on a submission by submission basis, grouped into two broad stakeholder categories, namely Schemes and Administrators, and Regulatory and non-aligned Bodies. Under the former we take issue with Profmed, Bestmed and Medscheme.
Some allegations raised by the Board of Healthcare Funders (BHF) and Department of Health (NDoH) are touched on in the latter.

Disclaimer: SAPPF's responses here are restricted to our experiences with the disciplines represented by us, in their negotiations and engagements with industry stakeholders. There may indeed be interactions between certain schemes and specialties that we are not aware of. We do not profess to speak on behalf of Pathology and Radiology in our submission or in this, our commentary.

1. PROFMED

*"Since there is no benchmark or ceiling tariff, service providers are in a position to charge any fee in the knowledge that the reimbursement of their accounts is "guaranteed" by a third party, i.e. the patient's medical scheme. PMBs have enhanced the **bargaining position of service providers** and effectively eliminated schemes' ability to negotiate with providers of services. The only mechanism medical schemes may utilise to mitigate their risk is to contract with Designated Service Providers (DSPs)."*
(§1.1 ¶2.15)

SAPPF's Response:

It is true that many Schemes use DSPs to manage their PMB risks; examples include Discovery Health, Fedhealth, Bonitas, and Momentum. Profmed however has, over the years, decided *not* to enter into DSP contracts with specialists. Profmed believes that it is able to manage their risk effectively at an average reimbursement rate of 140% – 150% of scheme rate for clinical and surgical disciplines.

"Medical schemes, especially small- to medium-sized schemes, are unable to enter into DSP arrangements with most service providers, most notably medical specialists and private hospitals – the main cost drivers of medical schemes."
(§1.2 ¶2.16)

SAPPF's Response:

This is not so. A number of these smaller schemes do in fact have DSPs, for example: Resolution Health, LA Health, Bestmed, SAB, Naspers and Netcare Medical Scheme. Certain schemes, especially through their lower-priced options, sub-contract the setting up and management of DSPs to third parties such as Care Cross, One Care and Prime Cure.

"It is submitted that the persons that make treatment decisions of patients should not be permitted to own shares (other than shares in listed public companies) or have financial interests in hospitals or similar facilities or in any high-cost equipment as this creates incentives to over-service patients who are not able to assess the need for or validity of services, or determine treatment options."
(§1.3 ¶2.51)

SAPPF's Response:

The large hospital groups tend not to invest in hospitals in less-populated areas as the patient flow is too low, there are few specialists to service what patients there are, and the return on investment is simply too low. That said, the large groups will invariably also not invest in hospitals in urban areas that do not yield a high margin. This is because they do not cater for ICU or High Care, nor do they use much theatre time. Pertinent examples would be Psychiatric Hospitals, Eye Clinics, certain Gynaecology facilities, and Day Clinics.

These hospitals tend to fall within the NHN Group and, in most cases, are owned by General Practitioners, Specialists, Psychologists, etc. Should these practitioners not be allowed to own shares in these hospitals, the patients seeking care from these facilities will be denied access to the healthcare they need. Centres of excellence (e.g. Urology Clinic in Pretoria) are often also not that attractive to the Large Hospital Groups.

It is also not practical to prevent practitioners from owning high-cost equipment. For a start Profmed does not indicate a price range constituting "high-cost", nor does it come up with a solution as to who then in fact should own this equipment. Much high-tech and expensive equipment is used in an out-of-hospital environment and is situated in the Doctor's rooms (e.g. Ultra Sound, Laser Equipment, Mammography Units, and most Ophthalmology Equipment).

To suggest that anyone other than the specialist doctor or other healthcare professional own the equipment is trite. It would be wasteful if not simply unfeasible. Other disciplines including Audiology, Bio kinetics, Clinical Technology, Optometry, and Radiography also reflect high ownership levels of advanced technological, imported and hence expensive equipment, the use of which is imperative for the provision of quality health care as per the disciplines' scope of practice.

Our statements above do not pertain to the ancillary disciplines of Radiology, Pathology and Radiotherapy as we do not believe them to be implicated in Profmed's comments either.

"The relationship between hospitals and medical specialists is inherently conflicted and perverse as hospitals need to build relationships with and garner the support of medical specialists through the offering of a variety of incentives to generate increased utilisation of facilities in order for the hospitals to achieve their profit targets."
(§1.3 ¶2.57)

SAPPF's Response:

This is an unsubstantiated statement by Profmed. No detail is provided nor is any evidence supportive of the substance of the claim. What it implies is, in essence, a ludicrous situation in which doctors would hospitalise or even operate on their patients purely to maximising profits for the hospital or for some other undefined and sociopathic incentive. Doctors are bound by ethical rules and their foremost objective is the good health of their patients. Profmed's statement is opportunistic and has no truth to it.

"In addition to PMSA, Profmed has contractual relationships with the following service providers, either directly or through PMSA, that provide services to its beneficiaries…"
(§1.3 ¶4.6 page16)

SAPPF's Response:

Opticlear is not, as Profmed states, a managed care organisation. It has not been an MCO for at least the last 6 years. The current official listing of MCOs available on the CMS website will prove us correct.

"*The role of administrators in the negotiation of tariffs with providers of health care services depends on the size of the relevant medical scheme, the size of the scheme's executive office and the qualifications and experience of the Principal Officer. Large schemes or schemes with large executive offices and with experienced and skilled Principal Officers might attempt to do their own negotiations with service providers independently of their administrators."*
(§1.3 ¶6.3.9)

SAPPF's Response:

Most medical schemes - with the exception of GEMS, Bonitas and Polmed - do not have large executive offices. Neither does Profmed. In 90% of instances, Medical Scheme Principal Officers, whether they are skilled or not, do not involve themselves in negotiations with professional health service providers at all. Schemes in general rely on their Administrators to do all or most of the negotiations. Schemes that are self-administered may engage with hospitals, but virtually never with the health professionals themselves.

"[The private health care sector is complex as a result of all the different stakeholders, incentives and legislation. The market structure has undergone significant change since 2004 when the Competition Commission intervened in the determination of tariff benchmarks by medical schemes and service providers. This intervention has shifted the negotiating power to providers of services to the detriment of schemes and, in turn, consumers. It has also resulted in ***individual schemes having to negotiate tariffs with thousands of individual providers****, all with different cost structures, which is impractical and inefficient. Beneficiaries,*

especially in small- to medium-sized schemes have, as a result, been adversely affected due to the inability of their schemes to negotiate appropriate tariffs. It is submitted that these market dynamics are anti-competitive."
(§1.7 ¶ 6.3.13)

SAPPF's Response:

Neither Schemes, nor Administrators, nor MCOs negotiate with either individual service providers or with their representative groupings. The reality is that schemes continue to use the "old" Rand Conversion Factor (RCF) used by BHF in 2003, later adopted by the CMS and then incorporated into the now defunct NHRPL and RPL from 2006 to date adjusted by CPI. SAPPF can provide the Commission with the necessary evidence that will prove that virtually all Schemes continued to use this RCF Tariff Structure for their Scheme Rates. Therefore no negotiations have been entered into. Where Schemes are administered by a third party, scheme rates are uncannily identical for all seemingly independent schemes administered by that Administrator. There is usually no non-aligned and impartial evaluation of these tariffs, and certainly no 'negotiation'. Schemes merely adjust by CPI across all codes and disciplines.

"Large medical schemes and medical scheme administrators generally have more information about market dynamics, i.e. utilisation of products and services, unbundling of procedure codes (i.e. to group a number of codes to charge for a single procedure instead of using a single procedure code), "up-coding" (i.e. using a code with a higher reimbursement value than necessary, which enhances the income of the service provider and increases medical scheme costs) by providers, prices of products and services and quality of services. They are consequently able to leverage sufficient resources to interrogate and analyse this information and use the results beneficially in the design of effective strategies and to engage more effectively in provider negotiations based on these analyses. Other smaller players do not possess similar capacity, which has a detrimental impact on their negotiating ability."
(§1.8 ¶ 6.4.3)

SAPPF's Response:

Profmed has chosen in most instances not to engage with representative bodies of specialist groups for the purpose of discussing data or coding anomalies. While larger schemes possess larger data sets, the reality is that few schemes and administrators (with the exception of Discovery) interrogate these, or use them as a basis then to engage specialist providers on the outcomes and trends detected therein. With smaller schemes, one finds that a smaller number of providers will usually service the small scheme's members. But the data sets available to smaller schemes simply replicate on a smaller scale those available to a larger scheme.

"The abolition of central tariff negotiations in 2004, and the abolition of the benchmark tariffs (i.e. the RPL) and the process of setting the RPL tariffs in 2010 not only impacted on the effectiveness of negotiations between medical schemes and providers of service, but also left a vacuum regarding the determination and assessment of procedural codes, i.e. the codes that are used to uniformly describe the services delivered by the various service providers. New codes are required to describe advances in medicine and new technologies. Similarly, processes are required to remove obsolete codes. There is currently no process in place to deal with these requirements."
(§1.9 ¶ 6.4.7)

SAPPF's Response:

Whilst there is currently no formal process in place to deal with coding changes, SAPPF has dealt with this aspect in its submission to the Commission through the proposed SACHI process, and maintains that approach is the most open, rigorous and defensible proposal built on tested best-practice globally to ensure world-class quality healthcare.

SAPPF wishes to point out to the Commission that it has openly invited Profmed to meetings where changes to coding was key on the agenda. Profmed representatives did attend, so it is disingenuous to proclaim no

knowledge of such engagements. ProfMSA, the administrator of Profmed, engages with specialist societies on a regular basis.

"Medical specialists are generally also not amenable to entering into DSP arrangements with medical schemes. This is a direct consequence of the scarcity of skills in certain disciplines and guaranteed payment under PMB legislation. As indicated earlier, professional societies and management groups of medical specialists also advise against such arrangements, which conduct is submitted to be collusive and therefore anti-competitive."
(§1.10 ¶ 8.4.5)

SAPPF's Response:

The allegation that specialists are generally not amenable to entering DSPs contracts is false. As stated earlier there are a number of large and smaller medical schemes that have effectively entered into DSPs. Profmed has simply chosen not to enter into DSPs.

Societies and Management Groups do not and cannot advise members not to enter into DSPs. Their membership is comprised of the very practitioners who, in their own independent capacity, may choose to do as they see fit. Groups do however caution members about entering into such arrangements when the underlying principles behind DSPs are merely cost and tariff-focussed, and therefore pay less heed to matters of quality, outcomes, peer review, profiling, coding, or strategic engagement with individuals or their representative groups to discuss these very important matters. We believe that the Discovery Health (Pty) Ltd's submission adequately deals with DSPs and their role in the private healthcare industry.

"Medical specialist societies often advise on coding guidelines and publish so-called "Billing Guidelines."61 These Guidelines could encourage the unbundling of procedure codes for specific procedures, i.e. charging multiple codes instead of one specific code for a procedure, which results in increases in the fees for those procedures. This inappropriate use of codes by service providers, which enhances their remuneration, has unfortunately been accepted and enforced by the Appeal Board of the CMS under the PMB legislation."
(§1.11 ¶8.5.3)

SAPPF's Response:

This statement is not true insofar as members of SAPPF are concerned. SAPPF can provide the Commission with copies of Billing Guidelines issued by some of the SAPPF member societies. These guidelines were issued, not with nefarious motives, but in order to clarify and simplify coding for members and to assist in discussions with Schemes and Administrators. Profmed will not be able to prove attempts at "unbundle[ing]" codes in these manuals. The reference to the *Kara v GEMS* case (note 62) is also not of relevance to this discussion as this matter referred to the non-payment of a modifier that was approved and published in 2009. The use thereof has subsequently been negotiated and approved by most schemes.

As brief history of the contentious modifier is provided here for the Commission's consideration:

CMS complaints to the CC regarding Modifier 0019 – a Timeline

2007. Modifier 19 amended by SAMA to include neonatal intensive care by Paediatricians.

09 June 2009: CMS Registrar and Acting CEO Patrick Matshidze issues Circular 12 of 2009 clarifying the use of Modifier 0019. The purpose of the Circular is to restrict the modifier's use to surgery under general anaesthesia (part (a) of the descriptor, allowing surgeons and anaesthetists to modify the price by +50%), and disallowing paediatricians and neonatologists from accessing the +50% inflator for treatments involving intensive care items (part (b) of the descriptor – an additional category that CMS claims was unlawful added by SAMA in its DBM).

(It must be noted that prescription of the use of modifiers to doctors is not in the mandate of the registrar of medical schemes. Also note that the registrar contradicted the ruling of his own appeal board in issuing this

circular, and contradicted himself in circular 28 of 2009 in which he says that services for neonatal intensive care must be paid in full when regulation 8 is satisfied).

29 September 2010: BHF meets with Paediatric Society representatives to discuss and resolve appropriate use of Modifier 0019. It issues a recommended "Guide to Billing for Modifier 0019 in Neonatal ICU." This defined the modifier as appropriate only for admissions to neonatal ICU (not high care B), to practitioner codes 1205-1210 only, and chargeable only by Paediatricians and Neonatologists. Effectively adopted part B, contested by CMS.

28 October 2010: CMS Registrar and CEO Dr Monwabisi Gantsho complains about the BHF to CC, saying that the September meeting constituted collusive bilateral negotiations between BHF and the Paediatric Society.

21 October 2011: Competition Commission issues Certificate of Non-Referral in the matter against the BHF

21 May 2012: Competition Commission receives complaint against the South African Paediatric Association (SAPS - *sic*) and SAMA alleging contravention of section 4 (1) (b) (i) of the Competition Act
31 May 2013: Competition Commission issues Certificate of Non-Referral in the matter against the SAPS and SAMA

05 July 2013: Referral of Complaint by CMS to the Registrar of Competition Tribunal. The referral was past prescription date by 5 days.

What SAMA did, the CMS alleges, was to append a sub-category of treatment thereto, namely "category (b)" which defines a subset of neonates requiring intensive care, and then publish it as SAMA Modifier 0019 in its DBM. This sub-category of care allows for specialists besides surgeons and anaesthetists - namely neonatologists and paediatricians - to claim payment for the procedure at +50% above reimbursement rates for the intensive care items referred to in paragraph (b).

In 2009, the CMS issued a Circular (12 of 2009) to clarify its position. It complained that paediatricians and neonatologists were abusing the descriptor. Council does not recognise the modifier 0019 for use in paediatric intensive wards and it feels that alternative interpretation of this modifier stemmed from collusive activity between the BHF and the Paediatric Society (*sic*) (SAPA). The Registrar first complained that the BHF's conduct (with the Paediatric Society) constituted collusion. The CC decided not to refer the complaint to the Tribunal.

CMS then complained against SAMA and SAPS (*sic*), claiming that they (with the BHF) independently endorsed this secondary category, encourage its implementation, and thereby have increased the costs of medical care for parents whose neonates fall under category (b).

"This is detrimental to the welfare of the affected consumers of neonatal intensive care treatment as it drives prices or tariffs for their intensive care treatment up."

The CC conducted an investigation into the above complaint and decided not to refer it to the Competition Tribunal. Its reason, as before in the complaint against BHF, was that "The Commission is embarking on a Healthcare Market Inquiry, primarily focused on the rising costs of health care in South Africa and determining the factors contributing to the observed escalations...Part of [this] involves investigating the determination and use of the tariff guidelines by healthcare providers."

The Commission decided that the conduct complained of will be dealt with under the envisioned inquiry. But the Complainant was entitled to refer the original complaint to the Tribunal if it disagreed with the decision. In its referral, the CMS says that it is inconceivable that the future inquiry will have any bearing on this complaint, which it believes is specifically narrow enough to warrant an independent determination by the Tribunal.

In short, and despite the CMS not recognising the modifier, it was accepted at least 10 times by the CMS appeal board when rulings of the CMS were challenged.

"There is also not effective and independent peer review of doctors' billing practices."
(§1.12 ¶8.5.5)

SAPPF's Response:

It is not clear who Profmed has in mind to do this independent peer review of doctors' billing practices. The fact of the matter is that there is virtually daily interaction between schemes, administrators, MCOs and the various specialist groups on the interpretation of coding issues, billing practices, possible unbundling, incorrect coding etc. This has been the case for many years. Profmed's Administrators themselves contact specialist representatives to discuss and resolve coding issues. In many other instances schemes would contact consultants such as HealthMan or Medcodelink directly for neutral independent advice or to facilitate a discussion with coding specialists within the various groups. We contend that an effective peer review system is already in place in most specialist groups.

2. MEDSCHEME HOLDINGS (Pty) LTD

SAPPF dealt comprehensively in its submission with the interrelationship between cost-plus-ROI models for establishing the true cost of medical interventions, reference price lists for administering the complexity of healthcare interventions, and ethical tariffs/top-down regulatory interventions to cap or manage prices charged. We do not deal with this debate any detail again here. We would strongly like to highlight critical shortcomings however into Medscheme's recommendations, and do so piecemeal below.

"Medscheme's active purchasing includes the profiling of healthcare provider."
(Part a §1 page6)

SAPPF's Response:

While they might do profiling no specialist organisation or individual healthcare practitioners have been approached, engaged with or openly involved in the construction, testing or outcomes of Medscheme's profiling. What purpose it serves then can only be an internal scheme need, because it is not explained how it could benefit providers or serve as a springboard for negotiation or engagement.

Some specialists are adamant that profiling is pointless and it does not work to achieve the purposes it was set out to achieve.

"The future of health risk management will be more and more focused on the facilitative approach, backed by utilisation and price management. Medscheme has embraced the facilitative approach and our focus on healthcare service provider relationships and the use of provider networks is evidence thereof. Medscheme's healthcare service provider network initiatives are used to facilitate and manage equitable access to appropriate and cost-effective care, within what is affordable."
(Page 7)

"The contracting of a specialist network requires close engagement with the specialist societies due to the influence they have over their membership base"
(Page 7)

SAPPF's Response:

This is not true for specialists. Medscheme does not engage proactively with these disciplines as it would have one believe, except on an ad hoc basis, initiated usually by the specialists themselves.

SAPPF agrees that close engagement is imperative. The fact of the matter is that the close engagement with societies or peer-review that Medscheme claims to undertake does not tally with SAPPF's experience.

*"Although Medscheme does not qualify to be a member, it has organised **specialist engagement forums** with the following societies:*

- *South African Society of Psychiatrists*
- *South African Society of Obstetricians and Gynaecologists*
- *South African Paediatric Association*
- *Ophthalmological Society of South Africa*
- *South African Society of Anaesthesiology*
- *South African Orthopaedic Association*
- *The Association of Surgeons of South Africa*

- *Association of Physicians of South Africa"*

(§6, page 10)

SAPPF's Response:

Medscheme then claims that it has established interactive forums "to address scheme-specific requirements and industry-related issues". SAPPF's members sit on the boards of the above-mentioned Societies and would therefore have reported the minutes of any meetings or engagement forums with Medscheme to the SAPPF Board. SAPA (South African Paediatric Association) is in fact a defunct association. It's only function is to arrange the annual conference. It has limited members, collects membership fees on an ad hoc basis only, and has no mandate to speak on behalf of the discipline, which is the authority of the Paediatric Management Group (PMG).

Medscheme fails to mention the very existence and role played by the various Management Groups, some of which have been in existence for 18 years, and who represent the commercial interests of specialists in private practice in terms of contractual service level agreements. No mention is made of HealthMan (exclusively representing SAPPF as administrator and consultant), while a now non-existent forum 'Focus Genius' is listed (which never did act for Optometry on industry forums anyway, or in matters of regulatory import), as is Spesnet – actually a commercial organisation, not a representative body.

SAPPF is aware of the Medscheme Specialist Forum which is a consultative body involving a spectrum of disciplines and of a similar GP forum conducted by Medscheme. A pilot project to test the impact of tiered-consults in 2014 was an example of one outcome from these forums. Unfortunately Medscheme used new codes to define the consults at the core of the test, resulting it little valuable data or much professional buy-in. We await an opportunity to interrogate the results and its conclusions.

"The 1.1% residual inflation could be limited if…

- *…*
- *Selective contracting of providers of healthcare as well as employment of medical practitioners is made possible through regulatory change in order to allow the development of innovative and more competitive healthcare delivery models.*
  Of course, the above results only analyse the trends in healthcare costs. The ***base level of claims*** *expenditure may be too high and it is clear that this is the case in many instances."*

(Part C §2, page 15)

SAPPF's Response:

All of this for 1.1%? Critically, no mention is made of overcharging by specialists, much less fraud or over-servicing, which is an immediate indication that residual inflation is a function of regulatory loopholes.

This 1.1% correlates with the inexplicable residual increase referred to by Discovery Health. SAPPF particularly takes issue with the implication that base level of claims may be too high. In terms of 'scheme rate' this may appear evident and justified. But as we have repeatedly demonstrated scheme rate is an "historical accident".

"The establishment of an independent coding authority to govern coding structures and set an industry reference price list will encourage transparency and enhanced competition: There is a need for an independent industry coding authority set up by the Regulator. This authority should assume responsibility for the governance of standardised coding structures and the setting of the relative unit values. It should review the coding structures and convene regular multi-stakeholder discussions to ensure that decisions are transparent and fair."

(Part C §6, page 17)

SAPPF's Response:

Do not mix coding and pricing. **The DoH, with the Competition Commission and the CMS, together conceptualised the National Health Reference Price List (NHRPL) for two reasons.** When medical schemes determined benefits, when providers set fees and when negotiations took place between providers and funders, the baseline on which these price determinations took place was the result of **historical accident** rather than a sensible understanding of relationship between price and cost. The list, and any future reference price list (serving as a minimum or maximum or some sort of sliding scale between the two) has to serve two functions: administrative standardisation and a scientific understanding of the true costs of healthcare services.

"Medscheme however propose the following qualifications and additions to accompany an independent coding authority structure:

- ***A MRPL is established**. A list of minimum reference prices (MRPL) should be set by the State at a level equivalent to the State **UPFS** schedule. This provides a reference price list only as a benchmark for the private healthcare industry."*

(Part C §8, page 21)

*The setting of a reference price list should be at a low level rather than setting it at the current average or maximum levels, or even levels based on cost practice studies in the private sector. If it were set at higher levels, or based on practice cost studies, the reference prices would become the de facto minimum prices in the industry and entrench existing inefficiencies. **The State UPFS fees provide a useful benchmark level against which to base the reference price list.** There would be differences between the UPFS schedule and the industry coding standard at first, requiring some analysis to target price equivalence. But this may over time converge to a national coding system which would be the ideal.*

(Part C §8, page 21)

SAPPF's Response:

A MRPL cannot be based on the UPFS (Uniform Patient Fee Structure). When the BHF in 2010 used reference to public hospitals to mean that remuneration levels therein should act as a ceiling in regard to PMBs, this assumed that public sector fees are lower than private charges. In truth, no one knows. Public sector fees are based on the UPFS, which is subject to critical shortcomings – poor data collection and severe rationing which skews the actual provision levels. **If public sector fees are lower, this is because they are not reflective of the actual costs of providing the benefit** as the UPFS furthermore fails to take into account operating and capital costs such as infrastructure, etc.

If this is in any doubt, we have reference to a 2010 Constitutional Court case *Law Society of South Africa and Others vs. Minister for Transport and [Road Accident Fund].* The applicants sought to challenge limitations to victims' compensation prescribed in amendments to the Road Accident Fund Act. This was unsuccessful. What was successful however was their attack on the constitutional validity of the medical tariff for health services prescribed by the Minister**. "On the facts, the Court found the tariff to be wholly inadequate and unsuited for paying compensation for the medical treatment of road accident victims in the private health care sector.** Accordingly, the Court found that the tariff is irrational because it is incapable of achieving the purpose which the Minister was seeking to achieve, namely to enable innocent road accident victims to obtain the health services they require."[i]

Other words used to describe the UPFS were "irrational", "retrogressive", and unreasonable". The **UPFS is so out-of-touch with the cost of medical services in any sector other than the ailing and poorly managed public one that, in representing the cap of compensation, it actively excluded victims from obtaining emergency care from private facilities, unconstitutionally infringing their rights to freedom and security of their person.**

We mention this because, had it played out on these terms, **there was legal precedent against the BHF's call for caps to PMBs using the UPFS as a benchmark.**

SAPPF fully endorses the criticism of a MRPL based on UPFS submitted by the South Africa Society of Physiotherapy. Again, the SAPPF preference is for a wholly independent body such as the South African Classification of Healthcare Interventions (SACHI) entity and it is towards the acceptance and establishment of such a body that we believe our efforts should be concentrated.

We advise the Commission, if it hasn't done so already, to subpoena the final report prepared for the HPCSA by actuary Shivani Ramjee, which should distil the core debate surrounding reference price lists and ethical ceilings.

"Medscheme position / recommendations
Medscheme proposes that PMBs are only paid in line with scheme rates, as per other benefits. However, the benefits must be clearly defined relative to an industry reference price list and providers must transparently display their billing rates relative to this reference price list."
(3.2.1. Page 31)

SAPPF's Response:

Payment of PMBs "in full" has previously been challenged in court and is again being brought before the High Court by Genesis Medical Scheme. SAPPF has lodged an application to intervene. The issue is currently *sub-judice* so we refer the Commission to our original submission for SAPPF's stance on the previous Court challenge. Nevertheless we do reiterate that the suggestion that scheme rates should determine the PMB reimbursement rate is illogical, as it would turn what is a *Minimum benefit* into a maximum benefit thereby ensuring that the adverse effects the legislation was designed to protect namely, family bankruptcy through catastrophic illness and the unbudgeted for dumping of medical aid patients on the state would continue to plague the industry.

Most of Medscheme's client schemes pay PMBs and other benefits at DSP rates, and not scheme rates already.

"Managed care organisations play a role in generating and sharing information on behalf of funders to promote competition. This information is used transparently for fee negotiations, strategic purchasing of care, selective contracting and to address waste and abuse. Strategic purchasing has been proved to be a powerful tool to improve provider behaviour."
(§7.1. pf72)

SAPPF's Response:

Even though MCOs can generate a tremendous amount of information, this is seldom shared with providers in order to promote competition, nor does any negotiations between MCOs, Schemes and providers stem therefrom.

"PMBs should be funded at a rate no less than this MRPL."
(§9.1. page87)

SAPPF's Response:

Should this recommendation be taken to heart, schemes will be entitled to reduce their reimbursement level from current DSP payment rates, down to scheme rate, and even further to this minimum reference price. This MRPL will by default become the maximum rate at which PMBS will be paid, as there will be no compulsion to reimburse above it. This will defeat the whole purpose behind PMBs, which is to ensure full cover without co-payment, financial catastrophe and increased burden on state facilities.

3. BESTMED

By way of introduction, SAPPF has noted statements made by Bestmed that correspond closely with ones that we have already responded to above in relation to Profmed. For example:

"The effect of this is that smaller medical schemes have diminished bargaining power vis-à-vis healthcare providers when they seek to negotiate more affordable and sustainable rates."
(¶5.7 page6)

SAPPF's Response:

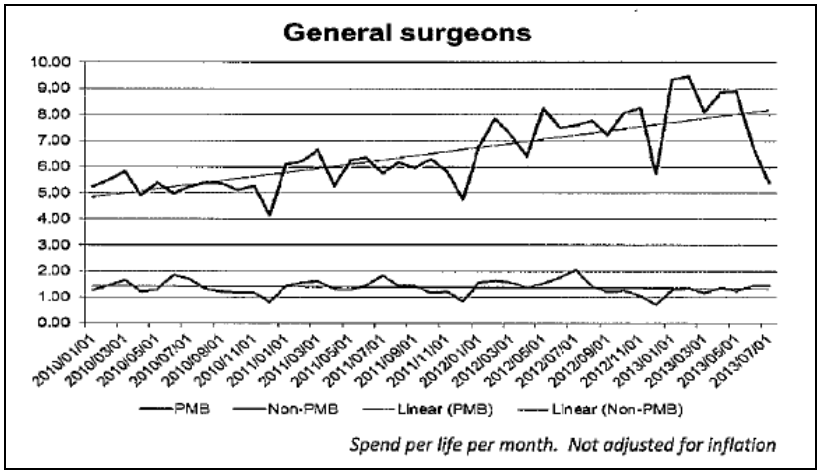
Bestmed is undeniably in the top ten schemes by size. It is by no means a "small" scheme. While it does in fact engage actively in tariff discussions with allied and Auxiliary Groups, it has chosen not to engage on tariffs with Specialist Providers or their Management Groups as Bestmed believes fundamentally that tariffs should not exceed Scheme Rate. Bestmed has outsourced its negotiating and specialist contracting to OneCare - part of the Carecross Group now owned by Metropolitan Health (MMI).

"Regulation 8 has removed the incentive for specialist healthcare service providers to agree to capped or preferential rates."
(§2.2 ¶77.1)

SAPPF's Response:

After this paragraph, Bestmed produces three graphs relating to the spending and charging patterns as percentages of scheme tariffs for Surgeons and Anaesthetists. It is not clear where Bestmed sourced these graphs from, who produced them, nor where one could analyse the underlying data – be it Bestmed data or not. One can speculate that it comes from a report produced by Health Monitor Group for the Board of Healthcare Funders (BHF). These very same graphs appear in other submissions as well (notably BHF's and the Department of Health's), but always in a selective context. The full source report has not been made available to our knowledge and it is therefore difficult to comment on these selective extracts without reference to it. One is also reluctant to hazard a response where the purpose for which the report was prepared is unclear.

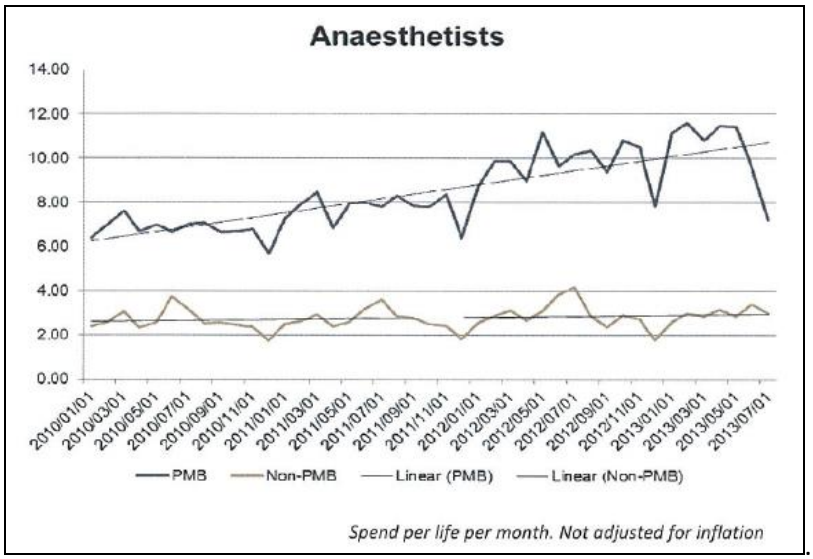
Suffice it to say that Bestmed draws its own conclusions from these graphs, which may very well differ from those of the of the report's authors. Bestmed declares that, "the graphs below demonstrate the charges for PMBs and Non-PMBs for general surgeons and anaesthetists, and bears out the disincentive that exists for healthcare providers to limit charges in respect of PMBs."



It is virtually impossible to come to this conclusion based on the graphs presented in this report alone. The linear non-PMB spend-per-life remains static for the period 01/01/2010 to 01/07/2013 at approximately R1.50, and is furthermore not even adjusted for inflation. The average CPI-based tariff adjustments over this period were approximately 6.0%, so it is difficult to comprehend the graphical implication that there has been a zero increase over this period.

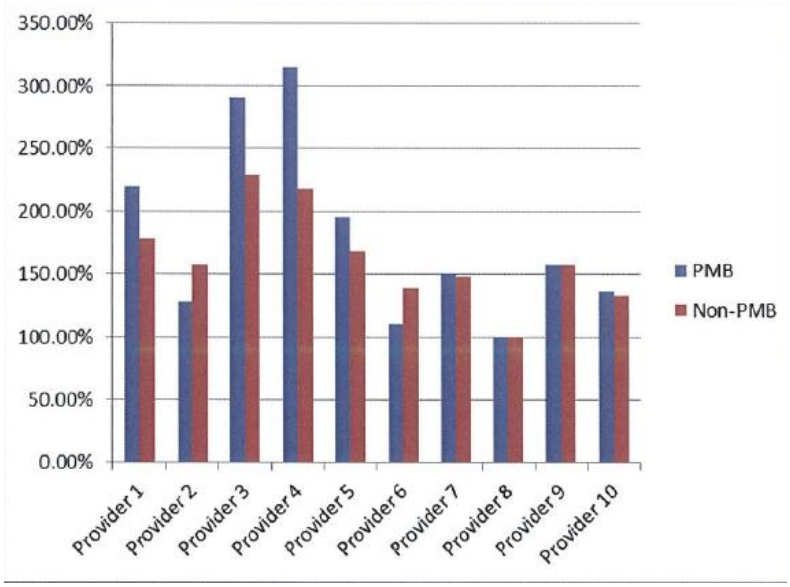
The report referenced apparently also does not explain the material variations in spend over this same period. General Surgery is not a cyclical discipline, in the same way as, for example, ENT Surgery is, especially in the winter months. What could possibly explain a decrease from R11.00 per life in March to May 2013 to R 6.00 per life in July 2013? It is also worth interrogating why the cost in July 2013 is even less than the cost in January 2010.

Bestmed then proceeds to produce a graph for Anaesthetists on page 62:



Whilst the cost per life differs from that of General Surgery, the rest is virtually a mirror image of General Surgery graph. Now, anaesthetists work across all surgical disciplines - from low-cost interventions in Ophthalmology, to high-cost interventions such as Neuro-Surgery and Orthopaedics. The patterns across all these disciplines will vary. Which makes it highly dubious that the two graphs above should mirror each other so closely.

Bestmed then produces on page 62 a bar chart of the 10 largest Anaesthetist practices in South Africa, ostensibly to prove its statement quoted above, regarding "…the disincentive that exists for healthcare providers to limit charges in respect of PMBs".



What the chart actually reveals is that 6 out of the 10 practices do *not* charge higher tariffs for PMBs: two charge marginally higher and two "materially" higher. The report does not state where these practices are located nor does it specify the area of specialisation defining the practices. To draw generalised conclusions on the charging patterns of all practices, as Bestmed does here, is not only irresponsible, but false.

Except for the limited submission on General Surgeons and Anaesthetists above, no further evidence is produced indicating that specialists charge excessive tariffs for PMBs.

"Open Schemes are reluctant to enforce DSPs…"
(§2.4 ¶112)

SAPPF's Response:

Our response to similar claims in the Profmed submission above refers. This statement by Bestmed does not reflect the current market position of Open Schemes at all. The Commission should note that the two largest Open Schemes, namely Discovery Health and Bonitas, make extensive use of DSPs. In addition, other open schemes more or less of the same size (by number of beneficiaries) as Bestmed make use of DSPs, e.g. Momentum Health, Fedhealth and Resolution Health.

Even restricted schemes have embarked on the contracting of DSPs, e.g. GEMS, Bankmed and Polmed. Once a DSP has been put in place, our experience is that Schemes actively enforce compliance of its members, and, where members choose to voluntary use a non-DSP, punitive penalties and co-payments apply. Schemes are therefore in a position to actively manage their exposure to PMBs.

As previously stated, Bestmed has outsourced its DSP contracting to Onecare. Indeed, a careful reading of their submission will reveal (in Annexure BM2, page 100) a list of Bestmed's contracted providers. A total of 1 014 specialists, SAPPF notes, have been contracted; more than likely at Bestmed's scheme rate.

"Specialists can charge exorbitant amounts that schemes can hardly challenge in the absence of a reference price list, a guideline price or so-called 'ethical tariff' …"
(§2.5 ¶114.1)

SAPPF's Response:

Since there is no NDoH-sanctioned/'official' published reference price, all schemes use the 'old RPL' adjusted for inflation (CPI) as their reference price. Schemes also publish these reference prices or 'scheme rates' on their websites. This is available to practitioners and members of the scheme.

Although certain doctors might charge higher tariffs (and we still dispute the alleged extent of this custom), market forces still apply; scheme members generally are price-sensitive and increasingly well-informed and therefore do enquire about tariffs.

When conducting pre-authorisations, schemes can also direct members to more cost-effective practitioners or at least specify to their members that practitioners deemed too expensive or outside of the network will charge private rates for which the member will only be reimbursed at scheme rate, making them responsible for the variable co-payment.

4. BOARD OF HEALTHCARE FUNDERS

"Private hospitals are very expensive and there is no proper monitoring and control to ensure the quality of the healthcare services they deliver relative to the price. Below is a table showing for various funders (A,B,C,D) the prices charged for Caesarean sections as opposed to vaginal deliveries and also for the removal of cataracts by the different hospital groupings. NHN refers to the National Hospital Network. A and C are smaller schemes while B and D are larger ones."
(¶6.3 pg. 26)

SAPPF's Response:

The graphs provided in this section, which attempt to show the vast discrepancies between the public and private sectors for a host of healthcare procedures, do not reference any source data. SAPPF would gladly comment, provided this is made publicly available. At face value the data seems highly dubious; it is in complicit with reputable studies already in the private sector. At the HASA conference in 2014, actuary Shivani Ramjee presented her findings, putting the difference at a mere 6%.

One must be exceedingly wary of drawing conclusions from benchmarks which may not be appropriate or comparative.

"Medical specialists in particular have taken advantage of the Competition Commissioner's invitation early in the previous decade to 'charge what they like' to the detriment of consumers who need their services. They usually also require the patient to pay cash up front for their services which causes hardship to many patients and is likely to prevent patients who do not have the cash to pay up front from having access to their services even if the patient is a member of a medical scheme. Members who have the cash to pay up front can subsequently claim it back from their scheme but this does not help those who don't have the cash. In the CMS report on 2012 claims, ***23.3% of claims were paid to specialists****, an annual increase of 10.3% after inflation. A distinction must be made between payment up front and advance payments. Payment up front means that the patient pays the doctor after the health service has been rendered and subsequently claims from his medical scheme. Payment in advance is where a doctor, before seeing the patient, requires him to make a payment either in part or in full prior to the service being rendered. The Health Professions Council frowns on practitioners who demand payment in advance but there are a few doctors who continue to do so. The consumer does not know that this is not allowed."*
(¶7.1 page 36)

SAPPF's Response:

This is an unsubstantiated statement. Most specialists tend to charge between 100 and 120% of scheme rate (as evidence by a 2012 report issued by the Health Monitor Company, penned by Christoff Raath). Up to 90% of medical specialists are contracted to large, medium and small schemes (open and restricted) at contracted 'fixed' rates.

Payments in advance are in contravention of HPCSA ethical rules, and is only permitted in exceptional circumstances where later payment is not feasible (e.g. Cosmetic Surgery which is excluded by definition, or foreign visitors making use of private sector healthcare services)

Most, if not all specialist declare their payment terms in notices displayed at the practice or by means of terms and conditions on patient consent forms.

The 23.3% of claims paid to specialists referred to above, it must be noted, includes payments to radiology, pathology, nuclear medicine and radiotherapy. In these instances virtually 100% of claims are at either

contracted or scheme rates. These rates have been agreed beforehand so any criticism of above-inflation increases included therein must fall to schemes and not specialists, who are price-takers in the contractual DSP environment.

"The problems experienced by medical schemes with regulation 8 of the Regulations under the Medical Schemes Act relate in large degree to specialists."
(¶7.2 page 36)

SAPPF's Response:

A medical scheme, in setting its rules, must be cognisant of the regulations. To limit payment for PMBs would be in contravention of the regulations. PMBs relate largely to specialist interventions

The BHF further makes reference, very selectively we might add, to Christoff Raath's report commissioned by the BHF. Bestmed did too and we have already criticised its selective use of Raath's data. To reiterate General Surgeons and Anaesthetists are not representative of the broader medical specialist market and we humbly request that Raath's full report be divulged in the interest of transparency and fairness.

"So-called "upcoding" by providers for the treatment of Prescribed Minimum Benefits is having a drastic effect on the costs of health care for medical scheme members…
Medical specialists make unrealistic demands on schemes, often charging more than 300% of what the scheme has allowed for in its benefits. This is not to say that what the scheme has allowed for is unreasonably low. It is the medical specialists that are overcharging."
(¶7.3 page 38)

SAPPF's Response:

There is no evidence provided by the BHF of trends of any significant upcoding, except for the tables on pages 39 and 41, which could be isolated incidences. Upcoding is not PMB-specific but could be evident for both PMB and non-PMB conditions. Procedure, diagnosis and prescriptions for conditions based on these must tally. For them not to tally (e.g. to diagnose a patient with pneumonia, hospitalisation, x-rays and medication specific to the condition must follow). Otherwise this is fraudulent and to generalise that 'upcoding' so defined is rife is disingenuous.

Scheme rates are a result of historical accident and not cost; so whenever charges in excess of scheme rate are reported (300% plus) it must be noted that these prices reflect the application of cost data. Services billed at scheme rates on the other hand are a direct result of schemes' coercive practice of paying members directly rather than the provider. Because this results in bad debts that providers find difficult to recover, practitioners working in less affluent areas will usually succumb to this backward pressure exerted by schemes and restrict their billing to scheme rates. In cases where non scheme rates are used, providers' attempt to cover costs through co-payments.

Claims per event will always be higher for PMBs than they will be for non PMBs usually because of the nature of conditions labelled as PMB diagnoses which generally are more serious illnesses than those not so labelled.

In summary, it is precisely the case that what schemes allow for is too low. 300% of scheme rate is approximately what recovery of cost models (based on verifiable practice cost data) recommend fees should be and therefore is not exorbitant.

"The coding system that is used by medical schemes and health care providers alike is being weakened by healthcare providers seeking to maximise their income to the point where it is becoming untrustworthy for medical schemes…

" In the same year, a new modifier 0016 was unilaterally added in respect of procedures performed on neonates with a weight of less than 1000g. The modifier is only to be used by paediatric surgeons. SAMA confirmed that a 50% rate increase is attached to this modifier."
(¶7.4 page 38-39)

SAPPF's Response:

The BHF actually means '0019' here. A timeline for the issue is enumerated above in respect of the Profmed submission. What the BHF does not mention, is that modifier 0019 was in fact approved by the Board and circulated to its members!

"There is no central standardising body on coding and medical practitioners, particularly specialists, have started making up their own codes in an attempt to earn more per procedure or consultation."
(¶7.6. page 41)

SAPPF's Response:

All code changes are in fact still reviewed by the coding committees of SAMA and SAPPF. If approved, it is then negotiated with schemes, who deem whether changes are necessary, valid and or reflective of current best medical practice in a particular discipline. Schemes do not have to reimburse for code changes so there is no unilateral move by specialists, and if there is, there is no proof that they are getting away with it to any flagrant degree, and certainly not without scheme knowledge. Examples can be found in the field of Cardiothoracic Surgery but these are hardly reflective of the greater specialist industry.

"The Health Professions Council made a ruling some years ago that members of the general public could consult directly with a medical specialist if they chose to do so. Before that there had been a rule that a patient had to first see a general practitioner and be referred by the general practitioner to a medical specialist if the GP thought that this was warranted. The GP acted as a gatekeeper to eliminate medically unnecessary consultations with expensive medical specialists. The HPCSA did away with this role of the General Practitioner thereby increasing the power of medical specialists beyond what it should be in the market place. This decision was inconsistent with government policy concerning a referral system of healthcare and resulted in the erosion of the role of GPs and dilution of their revenue. The HPCSA has since shown a marked reluctance to address this problem for reasons beyond BHF's understanding. It appears that the HPCSA process to review coding and pricing has stalled. While BHF agrees that the HPCSA should not get involved with the "reference" pricing of health service at this stage, the work on coding should go ahead as it involves scope of practice which is squarely within the domain of the HPCSA."
(¶7.9. page 46)

SAPPF's Response:

Schemes can set their own rules in this regard. HPCSA was never involved in coding or reference pricing – their ethical tariff presupposed a cost-based reference price list. The Pap smear example given under ¶11 for a gynaecologist is a case of a test taken in isolation when in fact the invoice is for a more comprehensive check-up. Depending on the clinical condition of the patient, it would be a perfectly acceptable and normal account and no doubt includes more than just the Pap smear. Nurses won't be able to conduct the test referred to. But if a GP billed for the same, he'd be quite entitled to charge the same as a specialist. The account is misleading and the clinical condition of the patient needs to be understood if the invoice is to be interpreted correctly.

5. NATIONAL DEPARTMENT OF HEALTH

"Broad Problem Statement
The private healthcare sector is often perceived to be functioning much better than the public sector, but this belies a number of chronic and systemic problems…"
(Box 1, Page 11)

SAPPF's Response:

This whole statement is emotive and unsubstantiated and we will deal with each point individually.

"…First, the hospital and specialist markets are concentrated, resulting in prohibitively high prices and an unequal playing field for fragmented purchasers… Thirdly, services are hospi-centric and curative in approach, with very little attention given to preventative and out-of-hospital care…"

SAPPF's Response:

SAPPF disagrees with the first point and in particular with the unsubstantiated comment that hospital and specialist prices are "prohibitively expensive". The claim that "services are hospi-centric" is simplistic and generalised. For example, Obstetricians and Gynaecologists in their private consulting rooms probably spend more than fifty percent of their time working out-of-hospital, performing preventative services such as antenatal care, pap smears, breast examinations, and giving contraceptive advice.

"…Fourth, there is no regulated standard regarding service definitions and coding, resulting in confusion for patients and perverse provider incentives…"

SAPPF's Response:

There is a coding guideline that serves to describe all remunerated services used by the professions. However, because of the CC's hasty intervention into bilateral market negotiations in 2003/4, the guideline (the Doctors' Billing Manual or DBM) has not been updated for the period 2003 to 2009. Negotiations between parties too have ceased, resulting in confusion for everyone, not just patients.

"…Finally, there is no transparency regarding costs and quality of services provided by health facilities, and thus no ability to assess fair pricing, productivity and value. In the absence of price regulation, these problems result in inflated medical costs, unaffordable premiums and subsequent contractions of benefit scope."
(Box 1, Page 11)

SAPPF's Response:

Finally, the statement that inflated medical costs arise from the absence of price regulation must be challenged on the basis that the usual outcome of price regulation is in fact the creation of shortages in the market (increased waiting times and supply-side restrictions), and a consequent rise in prices owing to the relative increase in demand.

"The challenges with efficiency are directly linked to the inequitable distribution of funds between private and public markets; Ataguba and McIntyre argue that per capita spending in the private health insurance pool is 6.2 times greater than spending in the tax funded pool."
(¶26, pg. 15)

SAPPF's Response:

The comment regarding the inequitable spend between the public and private sectors needs mention. This was dealt with in the SAPPF submission in some detail but it is somewhat disingenuous to compare the private money spent by private individuals on their own healthcare at little or no cost to the state in the private sector, with tax-payers money spent by the state in the public sector.

To inform policy, the WHO's definitions, directives and declarations, must be combined with associated guidelines. For instance, the WHO counsels developing countries to spend at least five percent of their GDP on preventative primary health care provision. One would do well also to look at the Abuja Accord (2001). Only four African Union member states in 2010 were compliant with the Accord, which commits signatories to spend 15% of their national budget on health. Most of them have been spending 5% to 10%. South Africa, for the 2010/11 Budget, allocated 13%. So it is falling short, although the parlous state of public health is not exclusively a question of budgetary constraints.

South Africa's budget allocation, from Treasury coffers, is around 4.2% of GDP. This would seem to fall short of WHO guidelines and the country's health outcomes certainly reflect poorly in comparison with those of neighbouring Africa, its trading partners in the BRICS bloc, and other emerging market economies. What the NDoH never tires of re-iterating, supported ideologically by academics and coalition cadres, is that South Africa's spend on health is actually 8% of GDP.

Where do they get the other 4%? From private expenditure on medical aid, of course. A minority of the population, for personal reasons, opts not to use government healthcare. A proportion of their after-tax income is spent on private cover so they will not have to.

Globally comparative statistics on per capita health expenditure contain varying degrees of private health spend. There are arguments that the latter crowd out public sector investment and more valid arguments still that per capita healthcare spend is a diaphanous index that hides more than it reveals. Nevertheless, they can be rather instructive. (First world examples provided here are used to contextualize the South African private healthcare sector. Adding public services into the reckoning drags the country down, sadly, to levels of war-torn Afghanistan. See the WHO's controversial World Health Report 2000 – a ranking that has since not been repeated, at least not by the WHO).

In 2009, the United Kingdom, Canada, and Australia respectively spent (in constant 2005 US$ PPP), $3,487, $4,363, and $3,233 on health per citizen per year. These three commonwealth countries have remarkable healthcare indicators, and epitomise what is generally understood of the welfare state. However, the state burden for the healthcare of its citizens is considerably less when we see that government spend comprises, respectively, 87.3%, 70.4% and 67% of these totals. The rise of private cover, which UK critics lambast as the "privatisation of the NHS", and which the Québécois government even tried to criminalise in 2005, actually reduces the state burden, respectively to $3,044, $3,071, $2,166.

In South Africa, access to healthcare facilities, of which there are 4,200 nationwide, excluding sick bays at schools or places of employment, is to all intents and purposes, already 'universal'. The WHO approved guideline ratio for population per clinic is 10,000. Efficiency, staffing and capacity aside, SA's 4200 clinics, hospitals etc., on average, cater to 12,000 to 14,000 people each. Decentralised, district-based health provision has been the Department of Health's greatest contribution to improving access for South Africa's disenfranchised and vulnerable. It is modelled on the Brazilian system, which is thus often cited as a comparable developing nation against which to gauge progress. So let's:

Brazil spends $943 per head, split half and half between state and private, which means that the Brazilian government is spending double what its South African counterpart spends per head on public health ($277).

In SA there are citizens getting high-quality care comparable with the best in the world, for considerably more affordable contributions than private sector buyers pay overseas. Yet, Minister Motsoaledi calls private health care "a monster that will swallow the country whole." That someone can access something that others can't is anathema to public officials.

"The market power displayed by both hospitals and providers means that they are price setters within the private health care environment. The inelastic nature of demanding for most hospital and specialist services serves to augment this market power. Profit-maximising specialists and hospitals are able to exert their dominance through price increases and price discrimination with relative impunity, and currently have no need to compete on either price or quality in order to attract patients."
(¶80)

SAPPF's Response:

The fact that 80 to 90% of specialists provide services at medical scheme rates illustrates that, on the contrary, the majority of specialists are price takers not price setters. Medical schemes control professional prices primarily through the expedient of direct member reimbursement when doctors charge a fee at variance from the medical-scheme reimbursement tariff, leaving the doctor to collect the money from the patient. This has historically proven difficult.

This pushback by schemes has over the years resulted in a number of undesirable practices: over-servicing and unbundling of codes being the most egregious.

The ten to twenty percent of specialists who do charge private rates (above the medical scheme rate) generally do not charge more than 300% of that medical scheme rate - a rate that practice cost studies, mandated by the RPL process, indicated was in line with amounts that ought to be charged. The 'ought' is not an unsubstantiated random fee, but a bottom-up cost-plus minimum required to keep the professions viable, for practitioners to pay themselves a market-related salary, cover their legitimate practice expenses, and earn a small return on the investment made in their practice.

It is of considerable concern to SAPPF that, despite *overwhelming evidence to the contrary*, the authorities in the NDoH do not seem to appreciate the costs involved in running a modern medical practice.

The graphs on pages 36 and 37 of the DoH submission need further interrogation to prove or disprove the veracity of the derivative argument that South African prices illustrated here are true of the majority of service providers.

"The agency relationship is a response to market failures, and seeks to mitigate some of the inefficiencies that would arise if patients had no assistance in determining their demand for health care services. This puts the provider in the position of both profit-maximising supplier and ethical agent. Analysing this tension is central to the inquiry process."
(¶87 page39)

SAPPF's Response:

The information asymmetry in healthcare is not an indication of market failure but a feature of the knowledge base gained at great cost to the professional to enable him or her to act as the advocate for the patient seeking professional help when anxious about some unexplained symptom.

It is therefore unreasonable to criticise professionals for exercising their knowledge and skill to treat the patients placed in their care. Having said that, it must be acknowledged that the fee-for-service system can assist unethical practitioners in maximising their profits. However, SAPPF would urge the Commission not to be persuaded into recommending regulations to manage the deviant practitioner. Regulations should guide

appropriate practice and the delinquent doctors should be managed as delinquents, punished by existing remedial procedures, fines and threats of expulsion from the HPCSA.

"One of the rules relating to practitioner ethical conduct precludes hospitals from employing doctors. This puts hospitals in a position where they are required to compete in order to attract medical specialists, so as to secure patient flow, and the money that follows these patients. Hospitals are also required to secure the patronage of specialists in order to meet the quality standards required by PHEACs in provinces as linked to registration of specialist beds."
(¶88 page40)

SAPPF's Response:

SAPPF does not support the employment-of-doctors argument and the reader is referred to the SAPPF submission for our reasons. If there is evidence of contracts in existence between hospitals and doctors resident in those hospitals which incentivise unprofessional behaviour, then SAPPF would like to see the evidence. It is the SAPPF view that, in the vast majority of cases, no such contracts exist. There is a subtle difference in contracts that incentivise behaviours and the purchasing of equipment to maximise patient care.

"The market power displayed by hospital and specialist results in price-setting power. Section 8, ''Pricing Benefit and Payment Options' presents the Department's recommendations regarding the establishment of a central authority responsible for reviewing cost data and facilitating negotiations between providers and medical schemes."
(¶100 Page 44)

SAPPF's Response:

SAPPF supports the idea of a *central authority for reviewing cost data and facilitating negotiations between providers and medical schemes,* and has for several years been promoting its SACHI concept with an emphasis on ensuring quality healthcare provision.

"First, the 'cost' of providing a service is defined as the expenses that a provider must face when delivering this service. There are a number of cost 'types' and it is the Department's experience that the private healthcare sector stakeholders lack consensus regarding the most appropriate cost structure to use in determining a final 'cost of service'. A cost-based methodology is central to establishing a fair price that allows for all parties to maintain financial stability."
(¶192 page69)

SAPPF's Response:

No. This is what NHRPL was all about. SAPPF disagrees with the Department's contention that there is a lack of consensus regarding the *most appropriate cost structure to use in determining the final cost of service.* The RPL process was developed for that purpose but it was never implemented because the NDOH did not anticipate the outcome of that process and refused to follow through with it. SAPPF fully supports a cost based methodology to establish a fair price that is honest and transparent, and acknowledges the true and relevant costs of running a modern medical practice.

"First, the 'cost' of providing a service is defined as the expenses that a provider must face when delivering this service. There are a number of cost 'types' and it is the Department's experience that the private healthcare sector stakeholders lack consensus regarding the most appropriate cost structure to use in determining a final 'cost of service'. A cost-based methodology is central to establishing a fair price that allows for all parties to maintain financial stability.
193. Second, a 'billed price' of a service refers to the balanced bill of a service, as invoiced by a provider. Currently, there are providers who practice 'split billing' where medical schemes are invoiced for part of the

service and patients receive the balance where any part is not covered by the scheme. This is an enormously damaging practice, and prohibited in terms of the Act. Without transparency about the final 'price' of the service it is impossible for full assessments of expenditure to be made. The earlier section regarding OOP payments has relevance in this regard. In South Africa, the billed price for services is largely left up to the discretion of individual providers."
(§8 ¶193 and 194, page 71)

SAPPF's Response:

The reason some practitioners balance bill is to overcome the difficulty of subsequently collecting benefits paid to the members by schemes. The scheme motive here is to manage the invoiced fee indirectly by making it harder for the doctor to collect the medical-aid portion of a balanced bill. By splitting the bill the doctor is simply trying to prevent the scheme from 'punishing' the doctor for charging patients more that the medical scheme rate. Split billing as a problem would disappear if schemes were consistent in whom they reimbursed, their member or the doctor. There is no evidence that split billing is happening except in isolated cases.

"In most instances price determination involves collective negotiation among associations of doctors, hospitals or health insurers on behalf of their members in order to signal the 'appropriate' reimbursement tariff for a service and to control the costs of healthcare. This is usually facilitated by government authorities: 'it is generally accepted across OECD countries that governments or public authorities play a proactive role in fostering the setting of prices in order to reach policy objectives. Research suggests that setting prices encourages providers to compete for quality, helps share financial risks between insurers and the provider; and can proactively prevent increases in prices of health care services in highly concentrated markets.'"
(¶206 page 73).

SAPPF's Response:

SAPPF supports a "Rule of Reason" approach to deal with information exchanges in situations of anti-trust analysis, as happens in most OECD countries. The ability of stakeholders to exchange information and divulge details regarding their competitive position is currently missing in the South African competition law setting, which is inhibiting useful and essential bargaining around price setting.

"Background to Reference Price List (RPL) in South Africa."
(§8.3.2 ¶214 page75)

SAPPF's Response:

The NDoH is incorrect in stating that the RAMS tariff formerly published in the Government Gazette was a regulated maximum price that providers could bill. It was a regulated maximum that *schemes* had to reimburse. Providers always had the choice to bill private rates if they wished. They still do.

The problem arose when the difference between the private rate recommended by MASA (now SAMA) and the RAMS (now BHF) scheme rate widened to an unacceptable degree. SAMA (and MASA before it) had been publishing its own private tariff long before 1994 as paragraph 215 seems to suggest.

"With hindsight, a more pragmatic approach would have been for the Commission to use section 4(1) (a) of the Competition Act, and allow parties to justify their actions. There is ample guidance in competition law and policy circles on how to deal with information exchange among competitors."
(¶218-219 page76)

SAPPF's Response:

SAPPF fully supports this view. Acting as it did in 2004, the CC has inadvertently caused an enormous amount of damage to the private healthcare industry, has compromised patient care, and caused considerable suffering for patients unable to access benefits for new procedures introduced after 2004. Even SAPPF's biggest challengers, the BHF, say (¶10.3 of their own submission) that "The Competition Commission's past decisions

regarding private healthcare have been deleterious to the industry and were taken as a result of poor perceptions and understanding of the private health care environment."

"In reality...medical service providers with market power deviated from the NHRPL when it suited them without any market penalty."
(¶223 page77)

SAPPF's Response:

The RPL process was supposed to make the cost of providing a service explicit in the reference price. The 300% billed by private practitioners was reflective of this reality. It accurately assimilated the true costs associated with running a private practice. It was reality most schemes accept, but it is a reality the NDoH refused, and still refuses to acknowledge, and which therefore resulted in SAPPF and others deciding to take the matter to court.

"…certain preconditions that must be met. First, a standard nomenclature must be available to identify services and secondly, there must be an agreed methodology to determine the cost components associated with a particular service, as well as a 'fair' return on investment. These preconditions were not met during the RPL process, resulting in difficulties with reaching consensus."
(¶227 page 79)

SAPPF's Response:

SAPPF resolutely disagrees with the final sentence of this paragraph. A closer reading of Ebersohn's ruling cannot fault SAMA or the private sector for the manner in which it participated in the RPL process. Any "difficulties in achieving consensus" were a direct result of evidence being unpalatable to the authorities.

"The RPL due for publication in 2009 was challenged soon after draft publication for comments. Various stakeholders including HASA, SAMA, and other individuals and associations of service providers lodged legal action against the Minister of Health and the NDoH…Primarily, the underlying regulations for determining the RPL were found to be invalid, due to the absence of consultations between the Minister of Health and the National Health Council. Although there were other challenges with the RPL process, it is important to highlight the fact that methodologically, the process could have been salvaged, but due to the invalidation of the founding regulations the publication of a RPL was impossible."
(¶228 page 79)

SAPPF's Response:

SAPPF urges the committee to familiarise itself with the RPL judgement, and with the various reports produced by KPMG and the Ministerial Advisory Committee - reports that have never been made public. Suffice it to say that SAPPF is not in agreement with the Department's account above. We are of the opinion that the NDoH deliberately failed to follow through with the RPL process because it unearthed factual data, resulting in the practice cost report delivered by SAMA, which provided irrefutable evidence for the true costs of providing world-class healthcare services in a modern medical practice setting.

It is the opinion of SAPPF that it is crucial for the Commission to interrogate the RPL saga if it is truly interested in arriving at an accurate determination of what private medical practices cost to operate. These should then be extrapolated to today's costs to determine a fair cost plus fee for service.

"Some of the challenges that the RPL process faced provide insight into the nature of the provider market. Most importantly, although providers paid consultants significant sums of money to produce practice cost studies, collate the information and summarise the data, the information that was submitted differed from that which the department's auditors found when they embarked on wide-spread data auditing. This meant that the

*representivity and reliability of the data submitted was brought into question, particularly since there were incidents of blatant overestimation of capital equipment expenses and other easily verifiable facts. This was particularly the case **for specialist practitioners' submissions**. Interestingly, the data audited for the general-practitioner submissions was found to be fairly accurate."*
(¶229)

SAPPF's Response:

SAPPF absolutely rejects the comments made in this paragraph. The committee needs to interrogate the audit reports mentioned above as well as the correspondence between KPMG and the consultants. The findings of those "questionable" reports should, in the interest of fairness and transparency, be made public, even after all this time. It should be noted that the consultants that conducted the specialist private practice cost studies were also the consultants that were used for the GP submissions. What was found acceptable in the one, and not the others, then can only be that some conclusions matched the department's initial biases, which others challenged them.

"The absence of a national tariff list means that each medical scheme compiles its own list of scheme tariffs. This creates huge confusion for the patients, as rates vary across providers and between patients, and co-payments differ significantly. The lack of transparency and accessibility also precludes the possibility of real consumer choice. In the face of multiple reimbursement rates providers are also more likely to bill at a figure that encompasses the majority of the schemes, resulting in upward price pressure."
(¶233 page80)

SAPPF's Response:

It is important that the committee appreciates that scheme reimbursement schedules currently in use have never been validated from a cost perspective. They are, as we have mentioned, the result of an "historical accident".

Providers that are forced by circumstances to bill for their services at medical scheme rates are therefore at a serious disadvantage as these benefits in no way reflect the costs of providing the service. More should be done to by way of education and guidance so that practitioners do not, out of mistake or desperation, occasionally over-service or unbundle codes.

"First, due to overlapping and duplicated codes, it is possible for providers to 'unbundle' services into the smaller components making up a complete service. Because PMBs are covered in full, and because payment is linked to the reported codes, this results in a situation where the sum of the unbundled procedures exceeds the charge for the bundled service. The consequences for financial risk and irrational expenditure are self-evident. "
(§8.4 ¶238 Page 82)

SAPPF's Response:

It must be emphasised that SAPPF does not condone either over-servicing or unbundling and is firmly of the opinion that the way to avoid these aberrant practices is to establish an independent pricing and coding authority that is able to publish a schedule of fair and transparent fees that are a true reflection of what practices cost to operate in the South African private sector.

"PMB 'up-coding' is said to take place routinely, and is viewed as one of the drivers of medical inflation and costs."
(§8.4 ¶240 page 83)

SAPPF's Response:

The PMB schedules are supposed to be updated every two years. The fact that the committee charged with this process has only met once in the past decade is partially to blame for problems surrounding these conditions. This committee must urgently be re-established to tackle long overdue problems in this area.

"Considering both international and local experiences, it is the Department's position that it is imperative that a reinvigorated approach to pricing, including billing, reimbursement and ethical tariffs, is required. This revised methodology should involve all role players in an open and transparent process, and should be driven by the aim of understanding the true cost of health services in order to determine a fair pricing structure. It is also noted that Regulation 8 (payment in full for PMBs) was never intended to exist in a pricing vacuum."
(§8.5. ¶244 page 88)

SAPPF's Response:

SAPPF fully endorses this statement together with the following recommendation that "a negotiation framework be established by National Department of Health, with the aim of supporting central, collective bargaining using a cost-based tariff structure as the point of departure. The proposed negotiation framework can be introduced through appropriate amendments to the National Health Act."

END

Sincerely

Dr Chris Archer (SAPPF Chief Executive Officer)
30/04/2015