



SUBMISSION BY THE SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS (SASA) IN DIRECT REPLY TO MATTERS RAISED BY OTHER STAKEHOLDERS AND PERTAINING TO ANAESTHESIOLOGY

1. INTRODUCTION

This submission is limited to the most pertinent matters raised by stakeholders relating to anaesthesiologists.

SASA will make themselves available to engage with the Panel further if any other matters are raised, or come to light, or if there are any uncertainty or further information required relating to this submission, or the submissions of other stakeholders. It must be noted that SASA is a volunteer-driven Society, with only one full-time employee. As such, SASA's ability to review, gather supporting data and broadly consult is severely limited by its resources. SASA has, thus, within this submission concentrated primarily on matters of principle and in providing constructive and proactive positions, as far as possible. Oral submissions and timeous notice thereof would allow for further research and consultation to be generated.

2. PRICE-TAKERS? OR PRICE SETTERS?

There have been many statements made within the submissions speaking to the power wielded by medical specialists, effectively holding schemes and patients to ransom by charging what they want, and thereby unreasonably driving up the cost of healthcare delivery. SASA is strongly of the position that medical specialists and, specifically, Anaesthesiologists, are price-takers, as opposed to price-setters.

The above, in our view, ill-informed position, is premised on a number of factors, namely:

It is acknowledged, as many stakeholders have commented, utilisation has increased, for the most part related to demographics (age, disease burden increases, etc.), adverse selection and buy-downs. The scheduling of patients for procedures, based on the aforementioned factors, lies in the hands of the surgeons or treating practitioners, and not that of the anaesthesiologist.

Secondly, it is argued that medical specialists have power over hospitals, as they are the mechanism through which patients are brought to one hospital group over another. Although

much of the allegations of perversity remains to be proven, insofar as anaesthesiologists are concerned, they, for the large part, do not have rooms in hospitals, and often work, and indeed *have to* work, in more than one hospital. Favours for “admission privileges” are therefore not an issue.

One of the major factors impacting on the ability of medical specialists to negotiate pricing for their services has been the consolidation and strengthening of the medical schemes. Most submissions by healthcare facilities (hospitals) provide the arguments and statistics in support of this assertion. When evaluating the data sources at the disposal and at display in the submissions by schemes and administrators, the balance of power is evident. An individual anaesthesiologist has to either accept scheme offers (there is limited opportunity to truly negotiate) or embark on a complex system of invoicing, debt collection and debt recovery, if the scheme chooses to not pay non-contracted practitioners directly. The rates being offered is a one-sided affair, as there is no consideration from the scheme as to whether this rate covers the cost, experience and skill of the practitioner.

To not accept the rate offered by the medical funder means that the medical specialist is forced to charge a co-payment from the patient. As medical scheme reimbursement rates move further and further away from the actual cost of service delivery, this has become a more common necessity. However, it is not a necessity welcomed by the medical specialist. In some areas and with some patients, the patient simply cannot afford the additional co-payment. In the interest of the patient, the medical practitioner often lands up discounting their services unreasonably. Where such discounting is not enforced by circumstances, the increased administrative and bad debt burden force even higher co-payment costs.

In summary, the current market forces, the role of the anaesthesiologist and the specific regulatory environment means that, even though a scarce skill, anaesthesiologists are price-takers and not price-setters or cost determinants.

3. TARIFFS

The fees charged by anaesthesiologists must be viewed in the context of the skills shortage, the mobility of anaesthesiologists (both locally and globally), the years of study to qualify (13 years at a minimum) and the intensity of such qualification, as well as the unique medico-legal risks associated with the profession. For example, all deaths of patients under anaesthetic are automatically unnatural and therefore subject to a medico-legal investigation under the Inquests Act and the Births and Deaths Registration. Working hours are not standard, as anaesthesiologists are required in all emergency procedures, often after hours and also in other unexpected situations, such as pain management or in Intensive Care Units.

An anaesthesiologist is simply currently not rewarded in a manner commensurate with their skill, experience, level of training and the time such training required.

Tariffs should also consider experience and patient outcomes, which in turn affects downstream costs such as length of stay in a hospital.

SASA has no power to, and do not attempt to regulate the fees that its members, or non-member anaesthesiologist charge. Its role in coding of professional actions are explained in the section below.

Several allegations are being made by stakeholders in relation to the tariffs charged by anaesthesiologists. These include:

- Excessive charges (e.g. “300% of what scheme has allowed”)
- Price differentiation between PMB and non-PMB conditions
- Code unbundling to achieve higher income levels
- Up-coding to achieve higher income levels

The BHF submission includes the statements that –

(a) “medical specialists make unrealistic demands on schemes” and

(b) “this is not to say what the scheme has allowed for is unreasonably low”.

The RPL High Court ruling showed the complexity in finding benchmarking models that accommodate the costs and risks associated with running healthcare practices, as well as ensuring adequate remuneration for healthcare professional staff. It is undisputed that the previous reference pricing and processes within the development of the RPL was not aligned with the practice costs studies that were submitted in support of benchmark tariffs.

In contrast, there is no valid data or information provided by the BHF to clarify how the “300%” figure (and off what) has been achieved, or why (according to which benchmark) it deems its member schemes’ reimbursement levels for professional fees as not being “unreasonably low”. There are examples where a member has contacted a medical scheme to query a level of cover and have simply been told that “your doctor is over-charging you”, or worse, such information is indicated on a statement to a beneficiary. Not only does this undermine the doctor-patient relationship with no justification whatsoever, it also shows how Medical Schemes, with their access to resources and the media, as well as, in many cases, the patient, control the narrative.

In contrast, submissions such as those of Discovery Health proudly state that they have been able to effectively control professional tariff increases. Medscheme stated that only 1.1 percentage points of its contribution increases above CPI can be attribute to cumulatively tariffs, new technology and others, the bulk of its above inflation increases relating to demographics (ageing and disease burden) and buy-downs. This is, in itself, telling.

As anaesthesiologists are price-takers, no current mechanism exists to determine what would be fair remuneration. In fact, the decision on what to remunerate, and how much to remunerate, lies solely with the medical funders. The “what to fund” lies within the coding system, which is addressed below. The “how much to fund” is currently an unequal process with no mechanisms in place to evaluate the fairness of the tariff. Due to the complexity of service, unequal access to and understanding and interpretation of data, SASA agrees that a

fully market-driven price determining mechanism is not realistic, without a benchmark for comparison purposes.

That said, price-setting, based on what is available to be offered rather than cost of delivery, is not sustainable. Given the current critical skills shortage, in the context of the medico-legal risks taken by medical practitioners and the difficult working hours, there must remain some incentive to undergo the extensive levels of training required of our medical specialists. We are already seeing, due to rising medical professional indemnity cover, a dramatic drop in gynecological and obstetric specialists selecting the field of training and ongoing work. A reasonable, although not excessive, tariff must be achievable.

SASA, therefore, supports the development of an independently and cost-plus based benchmarking tariff process. The governance within this process must be clear and strong so as to ensure optimum objectivity, transparency and fairness.

SASA is, however, very careful to stipulate a medical specialist who has extensive experience or unique skills should be able to charge at a rate that they feel is both equitable with their skill and experience and defensible in terms of the guidelines offered.

4. CODING

A code is a short descriptor of the exercise of specific professional acts. Coding is used to record, measure and evaluate the type of medical services provided. That is an information collation and reporting mechanism. Coding is also used as a basis for billing.

Anaesthesiologists charge against time-based units, but do not control the time the surgical procedures will take.

A perception is created in some of the submissions that specialists in general, and anaesthesiologists in particular, have manipulated and exploited the coding system.

Until fairly recently, there had been no unique anaesthesia codes. In 2006, the SA Medical Association suggested that, for this, one should move to the US coding system and SASA then aligned our coding system with the US-based codes.

If there had been a large-scale exploitation of the coding system, this would have come up in the very sophisticated forensic analyses of medical scheme administrators. SASA has been informed by the head of a large medical scheme's forensic unit that less than 1% of practicing anaesthesiologists have open investigations against them as relating to coding, dispelling this notion. SASA acknowledges that, as in any industry, there may be errant practitioners that practice financially outside of the majority. It is not reasonable to use these examples as the standard for any industry or profession. Without disclosure of errant practice across the majority, claims of malpractice should be considered vexatious. In light of this both SASA and the HPCSA are and continue to be available and perform their duties in censuring practitioners reported of being involved in errant clinical or financial practice.

In terms of “new” codes, we refer the Panel to the South African Medical Association (SAMA) submission, where this process and the changes made, were very well documented. As the majority of the procedures performed by anaesthesiologists relate to time spent with the patient, very few of the 600 new Codes introduced since 2006 through the SAMA, through a thorough and reviewed process, were anaesthesiology-related. As noted above, over 70% of anaesthesiology claims relate to time, and is out of the hands of the anaesthesiologist.

That said, under the current coding and funding regime, the medical funder (in our view unfairly and unilaterally) decides as to whether they accept new codes and, thus, payment for these new codes. In one specific instance, a medical funder has simply refused to accept any new codes for payment, thus implying that no new medical procedures or advances have been created in the last 9 years – a great unlikelihood.

Please see Annexure “A” for a letter from Insights, who did the original research and produced the slides referenced in the BHF and other submissions and that relates to the allegations made in relation to coding. It is noteworthy that more than one submission used the very same sources (such as that of Insight) to state how healthcare professionals “exploit” or “overcharge” – however no schemes-specific data are provided to be interrogated and to understand if this is indeed true, and if so, what the reasons for such manifestations would be.

SASA, as a result, supports the institution of a representative professional body who are qualified, experienced and knowledgeable about professional actions associated with care provided to patients and allow this independent entity to create a valid and accepted coding system for South Africa. This body should stand separate from any organisation or initiative aimed at attaching Rand values to the various codes.

There should, however, be an appropriate regulatory framework as to whether and under what conditions new codes must be accepted as valid by the medical funders.

5. Quality of care

Anaesthesiologists have a critical role to play in determining the recovery time of the patient. In this case, medical advancement has led to better ways to shorten recovery times and such a process called Enhanced Recovery After Surgery (ERAS) is not just the most cost-effective solution, but in the best interests of patient safety and health. SASA, through its guidelines, strongly supports all clinical pathways that enhance patient recovery timelines.

Many submissions have argued that some neutral, or “other” entity must take charge of the care-coordination and clinical pathways as some possible “negotiated” settlement. This role should remain in the hands of persons trained, registered and experienced to fulfill this role. Anaesthesiologists, internationally and locally, are at the forefront of patient safety issues and, by the very nature of their role and training, are very patient-centric. SASA takes this role very seriously, engaging in projects such as ESMOE (Essential Steps in Managing Obstetric

Emergencies), antimicrobial stewardship, Best Care Always programmes and the investment in and development of an Anaesthetic Network of South Africa (ANSA), a progressing capturing and reporting tool across the peri-operative environment. SASA invests substantially in training, not only its own members, but nurses and other support staff. They actively engage in research and develop numerous clinical and practice guidelines to drive best practice within the industry. A commitment to best practice includes finding the most cost-effective solutions to the provision of healthcare. In 2007, for example, SASA brought to the attention of the Department of Health an issue of inhalation anaesthetics and flow rates thereof that could ensure quality of care and save costs (see Annexures “B1” and “B2”).

Anaesthesiologists are committed to providing optimum care. Central to this concept of optimal care is the concept of the most cost-effective care. As such, SASA welcomes any initiatives that seek to enhance and improve a patient-centered healthcare service.

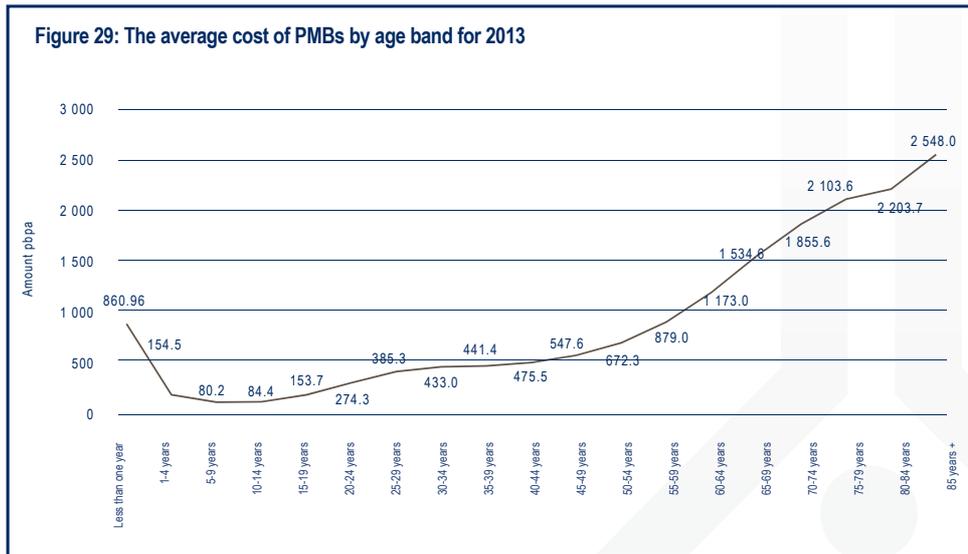
6. Prescribed Minimum Benefits (PMBs)

The PMBs are described in many submissions as significantly contributing to the above-inflation increases in the medical schemes sector, as well as for creating loopholes and uncertainty that could be exploited.

Firstly it is important to understand the incomplete regulatory framework. The PMBs were to have been accompanied by mandatory membership, and a mechanism for Risk Equalisation, as part of the Social Health Insurance (SHI) project. In this SASA support the numerous submissions on this matter, i.e. to correct or complete this regulatory lacuna.

Secondly, the failure to implement the requisite two-yearly review of the PMBs (required by the Regulations to the Medical Schemes Act), has not ensured that the PMBs keep pace with healthcare developments, some of which could be cost-saving, whilst also ensuring that the cost-effectiveness and affordability of the PMB package is assessed.

The CMS Annual report shows the cost of the PMBs per age band per month as below (the graph erroneously shows the cost as an annual average cost). The average monthly cost per beneficiary per month to provide for the PMBs are set at R512.80.



The average cost across all age groups is R512.8 pbpm which correlates very well with the SRM estimate of R508.2. The total amount paid for PMBs was R54 010 279 052 and this amounted to 53% of all risk benefits paid for 2013. The top 10 Diagnosis and Treatment Pairs (DTPs) are shown in Table 46.

Metropolitan Health reports the costs of providing the PMBs just under R700 per beneficiary per month. These amounts are surprisingly low, and total specialists case in the Metropolitan case make up only about R150 of the R700. Metropolitan also reports that PMB costs make up some 53% of its benefit costs, which given that it should form the core of any medical scheme option, should not be unexpected.

The view of the Department of Health that the costs associated with the PMBs could be managed by means of price regulation is unrealistic. Given the fact that most schemes and administrators report success in Designated Service Providers (DSPs) and provider networks and keeping healthcare professional costs in check, the fees charged for the PMBs appear to be realistic and in line with what the market expects. The need for a complete implementation of the regulatory project (which was done by means of proposed amendments to the Medical Schemes Act in 2008) cannot be avoided by simply attempting to regulate all prices that make up the costs of the PMBs.

In terms of price differentiation on the basis of PMBs, it can be clearly seen from the 10 practices selected by the BHF, on this specific charge against anaesthesiologists that only 4 appeared to have been charging more for PMBs than non-PMBs and some charging less. That being said, SASA has not been afforded the opportunity to interrogate the data of those four practices and the outcome may differ depending on the data and the analysis of documents (such as patient files) that underpin the collected cases.

The data used in the BHF (and other) submissions was generated on the anaesthesiologists, as an example only, and references a trend across all medical specialists, with some variance in scale. The data was also drawn from a relatively significant set of medical funders, but specifically excludes some of the larger medical funders where significant DSP agreements are in place. Where such DSP agreements are in place, the differential between PMB and non-

PMB rates is significantly reduced. The data shown, therefore, while not even fully demonstrating the real position in the marketplace, makes erroneous conclusions. The claims made specifically by the BHF with regards to PMB costings are unsubstantiated, with methodology unspecified, and appear to be conflicting. SASA does not believe, therefore, that these claims are warranted, based in fact or valid submissions.

This all said, SASA specifically opposes any fraud or unprofessional conduct, and would urge that any specific cases be reported to relevant authorities. SASA is able to undertake peer review in relation to the professionalism in coding and billing, and evaluate clinical data that underpins each case. SASA also advises its members that price discrimination between PMBs and non-PMBs is not permitted if the service rendered are the same. Specific instances of price discrimination should be dealt with through forensic and other mechanisms at the disposal of schemes.

7. BUSINESS MODELS FOR ANAESTHESIOLOGY

SASA addresses under this heading all matters raised pertaining to:

- The employment of healthcare professionals by hospitals and medical schemes (so-called HMO models)
- Shareholding in medical practices by corporates
- The Corporatisation of healthcare
- Integrated, or alternative business models for healthcare professionals
- Billing models (global fees and alternative reimbursement models)
- DSPs and network models

The anaesthesiologist, more than any other medical specialist, is accustomed to working in a team-based environment. The nature of their work, as mentioned above, is extremely patient-centric. As a result, SASA is not opposed, in principle, to any business or reimbursement model that seeks to co-ordinate care around the needs of the patient, optimises clinical treatment pathways or integrates delivery mechanisms. Any creative mechanism that enhances patient outcomes, does not impact on patient safety and that reduces the cost of healthcare provision should and would be welcomed by any profession.

That said, there are a number of imperatives that must be borne in mind when designing and proposing such alternative business models.

Firstly, the critical and specialist role of the highly skilled anaesthesiologist within the clinical team should be acknowledged and formally entrenched.

Secondly, it must be acknowledged that the medical specialist carries the entire medico-legal risk of treatment. Should any adverse event occur, the responsibility lies squarely with the medical specialist to justify his/her actions, or omissions. They also carry the risk of having to issue instructions to nursing staff and take an overall responsibility for patient outcomes within their scope of practice. The medical specialist must treat each and every patient on their individual merits and to the best of their specialist training. They, and only they, have

the skills necessary to make these decisions and, thus, the responsibility lies entirely with them. This means that treatment plans may not be defined by anyone other than the medical specialist responsible. Clinical independence is a local and global principle in medical practice, enshrined in the Health Professions Act, the Ethical Rules and various codes and policies of the HPCSA legislation.

This does not mean that SASA does not support the development of best practice treatment pathways, which should be set by professionals whose scope of their profession and practice, experience and skills make them suitable to do so. It does mean, however, that there should always be clear and unrestricted processes to allow a practitioner, at their own discretion and without punitive measures being implemented, to deviate from the treatment pathway if, in their opinion, such a deviation is warranted. Such deviation is recognized in legislation such as the managed care regulations (regulation 15H, Medical Schemes Act), in instances of harm, or possible harm to the patient, treatment failure and adverse events.

SASA is also strongly of the belief that no other entity or individual is in a position to define best practice clinical pathways other than itself. SASA has the process, knowledge and resources from both the private practice and academic environments, to develop the best, researched, peer reviewed and optimized guidelines. It is a role already fulfilled by SASA and one which it is prepared to allocate resources in the future.

Further, any optimised business model should be established through fair and transparent negotiations. It is not acceptable, nor legally allowed under the National Health Act, Consumer Protection Act and the HPCSA Ethical Rules, for the relative costs of the different components of a healthcare delivery model to be obscured from the patients and the other components. It is certainly not acceptable to ask one specialist to determine the value and, therefore, the fee of another specialist (there are many proposals where the Surgeon is offered a rate to share between themselves and the anaesthetist, at the Surgeon's discretion).

7.1 Employment and shareholding in medical practices by non-practitioners

SASA is not opposed to models in which corporates own shares in medical practices or where medical practitioners are employed by corporates, especially where such models allow for a more effective integration of a patient-centered medical delivery mechanism. However, where such models are introduced, the following needs to be considered:

The consequence of the current skills shortage of healthcare professionals in general, such as the gap in theatre nurses, and anaesthesiologists in particular would mean that direct employment of specialists would not necessarily lead to reduced costs, as the market competes for scarce talent. This is exacerbated by the fact that the skills of South African anaesthesiologists are recognised and sought after internationally. The Department of Health's Human Resource for Health Plan, 2011 (table 19) states the shortage of anaesthesiologists at 1312, which would have had to be addressed by 2015 to stand at 1006. SASA understands that there has been no increases in Registrar posts, so the shortage would

not have been addressed. In total. Only approximately 84 anaesthesiologists are trained per annum.

Employment and shareholding models must acknowledge the critical clinical role of anaesthesiologists in healthcare teams in determining the most appropriate clinical pathways to be followed by patients under their care. It should also not place them in any dual loyalty situations, and the local and global ethical rules in this regard should be entrenched in legislation, so as to protect their clinical independence and the right to differ from their employers, or the non-healthcare professional shareholders in their practice.

The potential for power abuse and perverse incentives that go against this fundamental responsibility of the medical specialist must be carefully guarded against. Processes whereby there is no mechanisms for employees to differ from their employer, and have those resolved in a manner that is in the best interest of the patient, would be bound for failure. As a matter of labour law, employees are bound to carry out all legitimate instructions of their employers. An employment relationship *sui generis*, one which acknowledges the ethical duties and clinical expertise of healthcare professionals, as well as their legal responsibilities for their patients and care within their registered field under the Health Professions Act, is required. In addition, employee review mechanisms cannot run in accordance with standard employment performance management principles, and provision must be made for peer review mechanisms. The Health Professions Act permits only persons registered in a specific category to make pronouncements on professional activities within the scope of that specific profession.

It is understood from the various submissions on this matter that the rationale for employment and/or corporate shareholding lies in the –

- potential to contain professional fees / tariffs, i.e. by employing a healthcare professional the cost of that person is limited to a fixed monthly cost;
- potential to contain associated costs, i.e. by for example limiting or prohibiting the employee from using certain techniques, technologies, medicines and approaches to care;
- care co-ordination and ensuring patient-centered care, i.e. ensuring that care is not duplicated (e.g. pathology tests), that care-givers align in ensuring that the best possible care is rendered by the correct professional at the correct time, and that nursing care supports the care pathway of a patient;
- shared responsibility for care and cost.

For any proposed legislative amendment, in the end aimed at ensuring greater access to healthcare (as is mandated by the Constitution), to pass muster, it has to rationally achieve its stated objective. This means that a thorough investigation would be needed as to whether the employment or corporatisation of healthcare professionals will indeed lead to lower cost (given the shortage of professionals), better or more effective control over the consumables and equipment used in healthcare provisions and whether employment is indeed a *sine qua non* for care coordination.

Lessons learnt in the space of pharmacy, where pharmacies may be owned by corporates, and where corporates may employ pharmacists, have to be considered in this debate. Research has shown that corporatisation and licensing (with medical practitioners that would be the Certificate of Need in future) have not led to a better geographical spread of pharmaceutical services,¹ and although dispensing fees at corporates are down to levels described by the Constitutional Court in 2005 as financially unviable, few pharmacies can survive without strong front shops, that sell a variety of non-pharmaceutical and even non-healthcare products. The Submission by the Pharmaceutical Society, representing pharmacists, to the Panel, is telling.

7.2 Integrated, alternative business models

It is being proposed by the SAPPF that Integrated Practice Units be investigated as an option where various types of healthcare professionals can work together in an integrated manner. SASA would support such models, where various professionals can work in a single team in a patient-focused manner. Economies of scale could be achieved, in terms of practice administration costs. Not all professionals would need to work in the same area, thereby ensuring better coverage than what is possible in smaller, or one-person practices.

Such a model would have implications in terms of the current prohibitions in the HPCSA of co-operation, employment and co-shareholding of practices across professional boards, as well as in terms of the practice code numbering system (currently administered by the BHF on behalf of the Council for Medical Schemes). When expanded to include professionals not registered at the HPCSA, such as independent nurse practitioners, social workers and pharmacists, legislative changes to more than the Health Professions Act would be required.

The advantage of such a model would be that the employer(s) would also be healthcare professionals subject to the authority of the HPCSA (and/or other applicable professional boards), thereby removing the possible conflict in terms of peer review and employer demands that may be at odds with professional responsibilities.

However, the principles of fairness and transparency must remain at the forefront of any such model to avoid the abuse of one practitioner group over another. Support and ancillary staff would be specifically open to such abuse, due to the power dynamics within the profession. Regulations should, again, guard against such exploitation.

8. Global fees and ARMs

SASA is also not opposed to global fee- and alternative reimbursement mechanisms (ARMs), provided that the following conditions are met:

¹ Ward et al, 2014 "Assessing equity in the geographical distribution of community pharmacies in South Africa in preparation for a national health insurance scheme" <http://www.who.int/bulletin/volumes/92/7/13-130005/en/>.

- Current barriers on these models as placed on professionals by ethical rules 7 (fee-sharing) and 21 (professional acts that cannot be subcontracted) are amended and incorporate mechanisms that would protect professionals and patients during such arrangements;
- The arrangements are based on sound clinical pathways and best evidence, in line with those set by professionals qualified and experienced to make pronouncements as to the care needed by patients subject to these arrangements, and, as noted above, SASA believes that it is its responsibility, as the professional Society, to perform this role;
- There are hardship clauses built into the arrangements, to ensure that patients who need extraordinary care under certain circumstances, are able to access it, without the professionals being penalized or taking an unacceptable risk;
- There is transparency in the invoicing and the services and goods being charged for, as mentioned above;
- There is room for clinical independence and patient-appropriate care;
- Reimbursement is commensurate with the level of risk undertaken as part of the global fee and/or ARM;
- All practitioners or groups willing to enter into these agreements are able to do so, and that criteria for participation includes both quality and price measures.

9. DSPs and networks

A serious allegation is made specifically against anaesthesiologists, namely that they are unwilling to contract with medical schemes. This is patently untrue. Please find attached two letters from medical scheme administrators stating the level of take-up by anaesthesiologists on their network / DSP tariff offers (Annexure “C1” and “C2”).

Anaesthesiologists even face a further incentive when it gets to DSP and network arrangements. As many anaesthesiologists do not see patients in consulting rooms, most patients are once-off clients and most patients are seen within the hospital setting. Without rooms and operating almost entirely in a hospital setting makes it difficult to ensure the completion of forms and contractual arrangements, secure payment for services rendered and collect debt from patients. It is also more difficult to collect co-payments that may be imposed on non-DSP or non-network practitioners. It is therefore administratively, logistically and financially better for practitioners to sign on to DSP and network arrangements, as that secures funding at a pre-determined level and paid directly to the practitioner.

It must also be borne in mind that SASA are unable to fulfill any coordinating work in this regard. It cannot, for example, recommend that its members enter into agreements, or not enter into agreements, as such action would fall foul of the Competition Act.

The inability of some schemes to contract may relate to matters of competition and business approaches, and one should consider the competition law impact of supportive measures aimed at assisting schemes unable to contract, to do so. For example, anaesthesiologists are

scarce and DSP contracts that promise guaranteed work, but unreasonable remuneration are not likely to, and should not, be easily signed.

What is of concern in relation to DSPs and networks, are the absence of a good regulatory framework in the Medical Schemes Act and regulations. Regulation 8 simply states that scheme may “select” a DSP for the care provided for the PMB conditions. It also creates exceptions where a patient may go outside the DSP network. The managed care regulations (regulation 15E) contain some provisions relating to ensuring patients are informed of the care they require and that there is no discrimination against possible contractors. SASA does not support the Medscheme proposal that DSP and network contracts should be exclusive.

However, the above legislative framework on DSPs and preferred providers stands in contrast to the substantive / normative provisions that protect other forms of managed care, such as disease caps, formularies and treatment guidelines. These mechanisms have to be set on “evidence-based medicine” and exceptions are created to protect patients who are in situations where the care to be funded by the scheme would be inadequate. No such provisions that would protect patients in terms of the level and quality of care rendered, exist in relation to DSPs or networks.

One of the key shortcomings of the current regulatory framework is that DSP and network offers are price-based, with limited or no measures in place in terms of the quality of care rendered, or the outcomes for patients.

SASA opposes the one-sided “selection” by schemes of the public sector as its DSP. Such appointments takes valuable, and scarce, resources away from patients who may, for example, have to use the public sector as its funder and provider. It also appears unfair to require of patients to pay a premium for some benefit, whereas they could have obtained the same benefit without having to make monthly contributions.

10. Information asymmetry

In the private healthcare sector there is information asymmetry in relation to patients who receive healthcare. Various legislative provisions are already in existence and enhancing the rights of the patient to make informed decisions may be more of a matter of enforcement and awareness, rather than requiring the development of yet another set of rules and regulations. These laws and rules include the National Health Act, the HPCSA ethical rules, the Consumer Protection Act and the Medical Schemes Act and regulations.

There is, however, also information asymmetry between anaesthesiologists, who are prohibited from colluding in, for example, collecting data to be able to better negotiate tariffs with medical schemes. Already in the submissions before the Panel is it clear which entities have the power of “big data”, and the ability to use that data in a manner that cannot be matched by individual practitioners. Whereas a practitioner will only have his or her own claims data, medical schemes and administrators have the data from all persons in that professional category, as well as data from all related disciplines (e.g. surgeons and specialist

physicians), the hospital and pharmacy. The development of global fees, ARMs or even just deciding whether a DSP or network offer is a good one, is therefore a markedly one-sided affair. Attempting to gain access to data, in order to co-determine models and risk-sharing proposals, is difficult, sometimes as a result of intellectual property claims. If anaesthesiologists are to form part of coordinated care projects, where parties share risks and responsibilities, access to data is critical. The absence of data also shows how anaesthesiologists are price-takers, and not price-makers.

11. Conclusion

SASA thanks the Competition Commission for the opportunity to give direct replies to submissions and allegations that affect anaesthesiologists. We reiterate our commitment to working with the Panel, as well as all other stakeholders, in finding new and creative ways in which improvements can be made. We are not committed to “business as usual” for the sake of remaining in a comfort zone and there are certainly areas where we feel we can both contribute to and improve the recognition of anaesthesiologists within the current private healthcare system.

However, we do believe there are some very serious possible unintended consequences to some of the proposals made in the submissions and that any changes recommended should be carefully considered and effectively regulated to mitigate any such unintended consequences or perverse incentives.

For any queries or further information, please contact: Natalie Zimmelman, Chief Executive Officer, SASA, at ceo@sasaweb.com or on 082-331-7846.