South African Private Practitioners' Forum

Submissions on the Provisional Findings and Recommendations of the Health Market Inquiry

SAPPF

SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM

1. Introduction

1.1 The South African Private Practitioners Forum ("**SAPPF**") is a voluntary association of private practitioners working in the South African private health sector. The organisation has a membership base of approximately 3000 specialists representing most specialist disciplines, as well as 3500 other practitioners, including General Practitioners and ancillary healthcare practitioners.

1.2 SAPPF supports the transformative elements in the Constitution and the Constitution's commitment to improve access to health care.

1.3 It is important to note that the scope of this submission on the Health Market Inquiry Panel's ("**the Panel**") Provisional Findings and Recommendations of the Health Market Inquiry ("**the Report**") has been deliberately limited to address only certain key elements of the Provisional Findings and also to observe that it should be read in conjunction with SAPPF's earlier submissions ("**SAPPF's 2014 submissions**").[1] Given the limited scope of the submission, it necessarily follows that there are many statements of fact and findings which SAPPF does not accept as being correct. For present purposes and in the interests of expediency, SAPPF simply notes that it reserves its right (and indeed that of its members) to, if needs be, address the errors of fact and finding at the appropriate time and before the appropriate forum.

1.4 To facilitate the Panel's review, SAPPF has grouped its submissions to address the following key topics:

1.4.1 the establishment of a Supply-Side Regulator for Healthcare ("**SSRH**");

1.4.2 the establishment of a Practice Code Numbering System ("**PCNS**");

1.4.3 coding systems;

1.4.4 the establishment of an Outcome Measurement and Reporting Organisation ("**OMRO**");

1.4.5 health services pricing;

1.4.6 provider networks; and

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[1] Section B of SAPPF'S Submission: Competition Commission Inquiry, Private Healthcare Sector, dated November 2014.

1.4.7 relaxing the Ethical Rules[2] of the Health Professions Council of South Africa ("**HPCSA**").

2. Submissions on the establishment of a Supply-Side Regulator for Healthcare[3]

2.1 The Panel recommends the establishment of a SSRH[4] which functions SAPPF understands will include, without limitation, overseeing and managing:

2.1.1 healthcare capacity planning;

2.1.2 economic value assessments;

2.1.3 the determination and implementation of appropriate payment mechanisms;

2.1.4 outcome measurements; and

2.1.5 registration and reporting.

2.2 SAPPF supports the establishment of an SSRH as an independent entity as soon as is reasonably possible. Our submissions in respect of the establishment of the SSRH are as follows:

2.2.1 *First*, it is critically important that the entity be completely independent from government and free from political interference.

2.2.2 *Second*, we propose that an interim arrangement be put in place for the five-year period during which the SSRH is being set up. We note in this regard that, given the scope and complexity of the SSRH's anticipated role, it is quite possible that the SSRH will take longer than 5 years to establish. It follows that an appropriate allowance should be made for this possibility. This should arguably include a 5 year block exemption to permit of multilateral tariff negotiations between provider groupings and funders.

2.2.3 *Third,* we recommend that the Panel procures the buy-in of key stakeholders, such as the Department of Health, in advance of its Report being finalised.

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[2] HPCSA's Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, published under Government Notice R717 in Government Gazette 29079 of 4 August 2006.
[3] We specifically refer to the findings and recommendations in Chapter 7: paragraph 156 (page 339), 312.3 (page 362); and Chapter 10: paragraph 84 (page 466), 137-138 (page 472).
[4] The Panel recommended that the establishment of the SSRH commence immediately with a view to it being fully functional within five years

2.2.4 *Fourth*, we refer the Panel to SAPPF's 2014 submissions, [5] in which it proposed the establishment of an independent coding and tariff setting authority, called the South African Classification of Healthcare Interventions ("**SACHI**").[6] SAPPF developed this concept based on the American Medical Association model of a permanent, independent, multi-stakeholder representative coding and tariff authority, comprising a secretariat of coding and tariff experts responsible for developing and maintaining a coding structure and related relative value units on which a non-binding tariff guideline would be based.

2.2.5 *Fifth*, SSRH should be the custodian of procedural coding and the rules pertaining to its implementation by healthcare professionals and should have representatives of health care provider groups on its board.

2.2.6 *Sixth*, a number of aspects are not addressed in the Report and must be clarified. These include the following:

2.2.6.1 to whom the SSRH will report;

2.2.6.2 how will the SSRH fit in and interact with other regulators, SACHI and the proposed National Health Insurance scheme; and

2.2.6.3 what roles will the HCPSA and the SSRH play, especially in relation to the question of licensing.

2.2.7 *Seventh*, SAPPF is concerned about the capacity of the SSRH to undertake the various functions envisaged in the Report and we recommend that the Panel reconsiders the extent of the SSRH's functions.

3. Submissions on the establishment of a Practice Code Numbering System [7]

3.1 The Panel recommended that the PCNS, which is currently managed by the Board of Healthcare Funders ("**BHF**") be assigned to the SSRH. Amongst other things, the Panel indicated that the PCNS will be the only number that

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[5] Paragraph 12 of Part B of SAPPF's 2014 submissions.

[6] The Panel's recommendations regarding the structure and essential attributes of the SSRH in a number of ways correspond to our suggestions in relation to SACHI. As such, we submit that SAPPF's 2014 submissions on SACHI will be useful in the establishment of an SSRH

[7] We specifically refer to the findings and recommendations in Chapter 5: paragraph 74-76.7 (page 91); Chapter 7: paragraph 304 (page 361), 310-312.2.3 (page 361-362); and Chapter 10: 84-86 (page 466), 147-151 (page 474), 90–92 (page 467). We also refer the Panel to paragraph 10 of Part B of SAPPF's 2014 Submission for submissions on principles and guidelines for establishing and maintaining an effective medical coding system; paragraph 11 for submissions on the OECD experience and justification for a central coding system; and paragraph 12 for submissions on SACHI.

may be used for re-imbursement of private providers.[8] In order to obtain a PCNS number, practitioners will have to submit information, including proof of registration with HPCSA.

3.2 SAPPF has not insignificant concerns around the current administration of the PCNS by BHF. These concerns are in summary the following:

3.2.1 BHF has imposed a system whereby practitioners are required to contract with the BHF in order to be allocated a practice code number ("**PCN**") upon payment of a registration fee after which the BHF levies an annual fee.

3.2.2 Although the fees charged using the PCNS are not excessive, they are increased annually at a rate above inflation.

3.2.3 SAPPF has reason to believe that the fees collected under the guise of administering the PCNS are not ring-fenced and are possibly being used to fund other BHF operations; and

3.2.4 Practitioners who do not pay the annual fee (for whatever reason) have their PCN "delisted" by the BHF with the result that those medical schemes who use the PCNS will not reimburse a practitioner directly for the provision of a health care service to its members; [9]

3.2.5 Schemes on being notified of a practitioner being de-listed often erroneously treat the provider as though they have lost their HPCSA accreditation, which causes them to communicate false information to affected consumers with not inconsequential financial and reputational consequences for the provider concerned.

3.3 Reputational considerations aside, the delisting of a PCN constitutes an unwarranted interference with the health service supplier's ability to receive compensation for the services provided to a patient in circumstances where the patient is a member of a medical scheme. As such, we suggest that the Panel recommends that this practice is halted when the PCNS (*or, better yet, the provider's HPSCA registration number*) is administered by the SSRH.

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[8] Chapter 7; paragraph 311 (page 361).
[9] Instead, the medical scheme is required to reimburse the patient directly who is then to on-pay the practitioner. Laura du Preez. Medical schemes must pay claims. http://ftp.bhfglobal.com/medical-schemes-must-pay-claims.

3.4 SAPPF also has the following submissions and observations in relation to the Panel's recommendations on the PCNS:

3.4.1 the PCNS described in the Report bears a strong resemblance to the SACHI model proposed by SAPPF;[10]

3.4.2 as already foreshadowed, consideration should be given to rather simply utilising the HPCSA number;

3.4.3 the PCNS should not be linked to the issuing of certificates of need;

3.4.4 the PCNS should be delinked from any outcomes-based registry;

3.4.5 it must be clear that PCNS registration merely entails providing details to the SSRH for the purposes of obtaining a PCNS number and, importantly, that it does not comprise registration in the strict regulatory sense;[11]

3.4.6 the funding of the PCNS must be cost-based and the use of the funds ring-fenced and transparent; and

3.4.7 the fee levied on practitioners should be once-off; alternatively the annual escalations, if any, must not exceed the rate of inflation.

4. Coding systems

4.1 While SAPPF does not in principle have an issue with the determination of codes and relative value units ("**RVUs**") being done under the auspices of the SSRH, it is of the view that it is highly unlikely that the SSRH will have sufficient resources or staff with the required knowledge to do so.

4.2 In the circumstances, representatives of provider groups affiliated to SAPPF should be represented on the SSRH. They will be in a position to, *inter alia*, provide the specific expertise required to guide code development and suggest changes following the emergence of new technologies and practice methods.

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[10] At Chapter 10: paragraph 150 (page 475), the Report states that the SSRH should be responsible for the adoption and standardization of actual alphanumeric codes, descriptors and relative value units. It recommends that motivation for new codes or modification of existing ones be submitted to the SSRH coding unit for consideration and final determination. Rules for introducing new codes or modification of existing ones is the responsibility of the SSRH coding unit, must be done by a multidisciplinary team and be developed in consultation with stakeholders and published.

[11] Response to Chapter 7: paragraph 310 (page 361).

4.3 SAPPF notes that the Uniform Patient Fee Schedule is inadequate and makes the following recommendations:

4.3.1 what is meant by "coherent, universally agreed coding system" and the type of coding system envisaged should be clarified; [12]

4.3.2 a more comprehensive universal coding system should be adopted;

4.3.3 particular consideration should be given to the hybrid model adopted by the private sector which is based on the American Medical Association's Current Procedural Terminology ("**CPT**");

4.3.4 the hybrid model referenced above should form the basis of a universal coding system for South Africa, which should be standardised across sectors; and

4.3.5 the procedural coding system should also be cross-referenced to a diagnosis coding system such as the ICD10.

5. Submissions on the establishment of an OMRO [13]

5.1 The Panel recommends the establishment of an OMRO that will be established in two phases, the first of which should be financed by funders and providers. Providers will be mandated to provide outcomes data to the OMRO.

5.2 SAPPF recommends that -

5.2.1 the metrics that will be applied are specified. Outcome-based measurements should be based on international standards, clinical measures and a specific treatment protocol. There should be discipline and condition-specific measurements; [14]

5.2.2 provisions in respect of quality of service must be aligned with the National Health Insurance Bill, 2018 ("**the NHI Bill**)".

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[12] Response to Chapter 5: paragraph 75 (page 91).
[13] We specifically refer to the findings and recommendations in Chapter 7: paragraph 98-104 (page 453); and Chapter 10: 164-171 (page 477-478). SAPPF's views on treatment standardisation, treatment protocols and international benchmarking are set out at paragraph 6 and 7 of SAPPF's information request submission ("**Information Submission**") dated 12 June 2015.
[14] Response to Chapter 9: paragraph 104 (page 453).

5.3 It is unclear to SAPPF where funding for the first phase will come from, as providers should not be expected to fund the phases.[15]

5.4 Finally, it is at odds with the appointment of the other structures' board that the OMRO board members are appointed by the President.[16] Although, we note that this paragraph is inconsistent with paragraph 169 of the Report which provides that the board be appointed by the Minister of Health. Clarity on the correct recommendation is accordingly required.

6. Submissions on health services pricing[17]

6.1 The Panel, in making recommendations in relation to price determination:

6.1.1 correctly observes that there has been a tariff vacuum" since the CMS' National Health Reference Price List ("**RPL**") challenge and criticises Department of Health's failure to publish a revised RPL. The Panel's recommendation, at least insofar as providers represented by SAPPF is concerned (*which therefore excludes the hospital and pathology groups*) is that a form of "collective bargaining" takes place, facilitated by SSRH;

6.1.2 expresses concern about the lack of effective alternative reimbursement models ("**ARMs**") in the market.[18]

6.2 Insofar as the ARMs are concerned, we note the following:

6.2.1 ARMs are relatively prevalent in the market in the form of global fees, capitation, and performance-based schemes. On the information available to SAPPF, these arrangements have proven to achieve not insignificant savings and accordingly benefits to consumers (which ultimately impact on their premiums) by reason of, inter alia, the following:

6.2.1.1 capitation of risk; and

6.2.1.2 better coordination of care;

6.2.1.3 the pooling of resources and the associated efficiencies; and

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[15] Response to Chapter 10: paragraph 164.2 and 171 (page 477-478).
[16] Response to Chapter 10: paragraph 103 (page 468).
[17] We specifically refer to the findings and recommendations in Chapter 7: paragraph 302-303 (page 360-361); and Chapter 10: 109-134 (page 469; 471). We also refer the Panel to paragraph 5.3 of Part B of SAPPF's 2014 for submissions on pricing methodology and paragraph 6 for submissions on Medical Scheme Tariffs and Reference Price Lists. See paragraph 16 of the SAPPF's 2014 Submission for recommendations to improve accessibility and affordability in the private sector, specifically paragraph 16.1 on the future of provider payment systems, which include submissions on ARMs.
[18] Chapter 7: paragraph 302-303 (page 360-361).

6.2.1.4 the need for co-payments is often removed.

6.2.2 ARMs are a matter of negotiation between funders and private practices;

6.2.3 Some ARMs, if implemented, may result in the breach of other legislation e.g. the Prevention and Combating of Corrupt Activities Act, 2004 (*thus to be able to properly implement a varied range of ARMs there will need to be associated legislative reforms*). An example of this would be a Global Fee Scenario where a healthcare professional is paid a fixed rate and chooses to not provide a treatment that a patient clinically requires, based on the direct cost impact of the treatment on the reimbursement the professional receives. This would contradict *Ethical rule 7: billing and sharing* of the HPCSA, which states "(3) A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under-service, over-service or over-charge patients." This could lead to a situation where the provider is therefore induced by the payment model from the scheme to underservice the patient, qualifying as corruption, according to the definition.

6.3 SAPPF supports/ recommends the following for the purpose of pricing health services:

6.3.1 discipline specific non-binding pricing guidelines (which permits of co-payments) be developed based on input costs. This will provide an appropriate baseline against which to measure/monitor/evaluate pricing in respect of each discipline;[19]

6.3.2 a deadlock breaking mechanism be adopted, such as pendulum arbitration to resolve tariff conflicts between stakeholders;[20]

6.3.3 a mechanism for accommodating differences in practice costs even within disciplines must be established to avoid "dumbing down" of available services;[21] and

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[19] Response to Chapter 10: paragraph 119 (page 470).
[20] Provided the arbitrator is appointed by a judge and is competent to understand such matters, and is not the Minister of Health. Response to Chapter 10: paragraph 120 (page 470).
[21] Response to Chapter 10: paragraph 126 (page 470).

6.3.4 multilateral negotiations should be undertaken within the ambit of the SSRH.[22]

7. Submissions on provider networks[23]

7.1 In relation to provider networks and designated services providers ("**DSPs**"), we point out the following:

7.1.1 provider networks are a form of ARM. These are not negotiated but are unilaterally imposed on providers;

7.1.2 currently, provider networks are price-based and there is no quality component;[24]

7.1.3 providers are not in a position to accept financial risk transfers from funders.[25]

7.2 SAPPF proposes that quality measurement should be applied to network providers and that there be a more appropriate determination as to whether a network provider falls within patient's network. Alternative methods of determination include the maximum travel time to a network provider or the travel distance from a network provider.[26]

8. Submissions on the HPCSA's Ethical Rules of Conduct for Practitioners [27]

8.1 The Panel has made a number of findings and recommendations in relation to the review of the HPCSA's Ethical Rules. The Panel finds that the rules, and their interpretation by the HPCSA, frustrate innovation and reform, especially of business models and that all rules should be reviewed from competition perspective. It recommends relaxing the Ethical Rules and their application in relation to fee-sharing, multi-disciplinary practices and sharing of rooms. These practices should be allowed under appropriate circumstances, especially where it would lower health care expenditure. "Team-based care" should be encouraged, but clear guidelines are needed as to when these

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[22] Response to Chapter 10: paragraph 131-134 (page 471).
[23] We specifically refer to the findings and recommendations in Chapter 10: paragraph 155-156 (page 475-476). We also refer the Panel to paragraph 14.3 and 14.4 of the Part B of SAPPF's 2014 Submission for submissions on designated service providers ("**DSPs**").
[24] Response to Chapter 10: paragraph 155.5 (page 475).
[25] Response to Chapter 10: paragraph 155.4 (page 475).
[26] Response to Chapter 10: paragraph 155.2 (page 475).
[27] We specifically refer to the findings and recommendations in Chapter 7: paragraph 313-314 (page 362), 133.3-233.4.2 (page 331), 250-261 (page 354-356); and Chapter 10: 175-175.4 (page 478-479), 176-176.2 (page 478-479). See paragraph 8 of the SAPPF's 2014 Submission for submissions on the employment of doctors and paragraph 9 of the Information Submission for SAPPF's view on HPCSA Rules that restrict competitive, efficient outcomes.

practices are permissible. This sentiment is echoed in the NHI Bill, which also reveals a preference, and requirements, for multi-disciplinary practices.

8.2 The SAPPF's view/recommendations are as follows:

8.2.1 The SSRH should assume the responsibility of applying and monitoring the HPCSA's Ethical Rules.[28]

8.2.2 In respect of the recommendation that **global fees** must not be prohibited by the Ethical Rules, while SAPPF supports this recommendation, the Panel should bear in mind that there is a risk that the application of global fees may encourage underservicing and that appropriate rules must be put in place to mitigate this risk.[29]

8.2.3 Regarding **fee sharing**, SAPPF is generally in favour of ARMs and to the extent that the Ethical Rules restrict them, they must be revised by the HCPSA. The rules against fee-sharing should not restrict the development of innovative ARMs. Challenges may arise in the context of global fees, which is a form of fee sharing, e.g. who bears the risk of complications.

8.2.4 Regarding the employment of doctors:

8.2.4.1 SAPPF points out that there is a distinction between hospitals employing doctors (sharing of fees between different specialists) and group practices. SAPPF notes in this regard that it supports the position of the Panel to the extent that it does not favour unrestricted employment of doctors, as there is a need to prevent "revenue maximising" behaviour and therefore it should not be allowed where motivated by "fee-sharing or "profit motive".

8.2.4.2 On the basis of research done to date, it has yet to be demonstrated that employment of doctors reduces costs. SAPPF does not generally favour the employment of doctors, because it carries the risk of perverse incentives (it encourages over- or underservicing, as the case may be). However, there may be

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[28] Response to Chapter 10: paragraph 176.4-176.5.3 (page 479).
[29] Response to Chapter 7: paragraph 131.2.2 (page 331).

exceptions where the employment of doctors in specific disciplines is appropriate, such as obstetrics and gynaecology.[30]

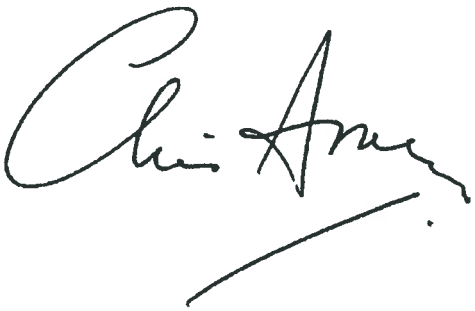
8.2.5 Regarding financial interests in hospitals,[31] SAPPF points out that many non- network hospitals owe their existence to the doctors establishing them. These shareholdings should be allowed to continue even if ultimately the hospital is sold to a network. That said, SAPPF does support the termination of exclusive arrangements.

8.2.6 Regarding abuse of medical savings accounts benefits,[32] the use of lower rentals as an incentive[33] and over-servicing[34] by way of the choice of the use of high care or intensive care, these outcomes are arguably the exception and not the norm. That said, bears emphasises that SAPPF certainly disassociates itself from these practices.

9. Conclusion

We trust that you will take our submissions into account in preparing the final Report and welcome any requests for additional input.

Yours sincerely,



[30] As more females enter the obstetrics and gynaecology profession and with the current security concerns in many areas where private hospitals are situated, it is becoming more and more unsafe for practitioners (especially females) to travel at night to do normal deliveries.
[31] Response to Chapter 7: paragraph 273 (page 357-358).
[32] Response to Chapter 5: paragraph 137 (page 102).
[33] Response to Chapter 6: paragraph 246.3-246.6 (page 215).
[34] Response to Chapter 7: paragraph 138-141 (page 334-335).