SA OPTOMETRIC ASSOCIATION (SAOA): SUMBISSION TO THE HEALTH MARKET INQUIRYN FOR ORAL PRESENTATION AT PUBLIC HEARINGS

We would like to extend our appreciation for the opportunity to participate in the oral hearings as arranged by the Health Inquiry Panel.

1. Executive Summary

Optometry is a healthcare profession that is autonomous, educated, and regulated and optometrists are the primary healthcare practitioners of the eye and visual system.

The SA Optometric market is worth an estimated R2,3 billion which represents approximately 2 % of the total healthcare market.

Optometric services are provided via primarily 3 different business models, namely, franchises, groups and independent practices. Furthermore, practices operate in different types of location which include, e.g. shopping malls, medical centres and private homes.

There exists a dichotomy in optometric practice in the private sector in that optometric practices are characterised by a professional component and commercial component

The practice of optometry is significantly influenced by factors which include the HPCSA Ethical Rules and particularly by interventions instituted by medical schemes, which, in many ways are to be considered as price drivers within the overall optometric industry.

Nevertheless, a number of such factors appear to lessen competition in the market being disadvantageous to both providers as well as consumers of care. This submission places emphasis on the following:

1.1. The Designated Service Provider

The medical scheme is a major force within the lives of healthcare providers in South Africa including the profession of optometry. The power of medical schemes in 'dictating' services and medical devices to be provided ('benefits') and related costs impact significantly on the lives of both providers and members of the public, from ethical and legal perspectives.

The proposed oral submission refers primarily to the anti -competitive conduct of designated service providers who operate on behalf of medical schemes on the basis of their abuse of dominance within the optometric managed health care environment under Section 8 (c) or alternatively under Section 8(d) (i) of the Competition Act which significantly impairs competition, alternatively, and in any event, have anti-competitive effects, and have no pro-competitive consequences.

Furthermore, members of the public have their rights of choice confiscated as they are directed to practitioners as determined by the DSP's.

1.2. Advertising, Touting and Canvassing

The SAOA fully supports the principle of responsible communication to facilitate informed choice by consumers of health care. However, the SAOA is concerned about misleading and vague messages incorporated within advertising and thus supports the principle of a regulatory framework.

Such a regulatory framework is to address specifically vagueness of messages which include % discounts, 'prices ranging from and 'terms conditions apply'.

Furthermore, it is recommended that the advertising rules, instituted by the HPCSA be enforced by another body such as the Advertising Standards Authority.

1.3. Mobile Practices

The mobile practice does serve a purpose and does benefit certain communities and individuals. However, problems with practice standards, reliable follow through and ownership have been experienced. There are also possible competition related considerations regarding the restrict trading of mobile practices

The rendering of services via mobile practices needs to be controlled. However, approval should not be restricted to those areas considered to be adequately serviced (what are the criteria?). The wording of the PBODO Guidelines needs to be reviewed. Standards of practice and the visual welfare of patients should remain the priorities.

1.4. Motivation for Deregulation

In accordance with the principle of the avoidance of no commercial influence over professional discretion, the SAOA has adopted the position to oppose submissions which advocate the deregulation of ownership of practices.

.

2. Background

2.1 The SA Optometric Association (SAOA)

The SA Optometric Association is a Professional Associated registered as a Non Profit Company (NPC) representing the majority of optometrists registered with the Health Professions Council of South Africa. Membership of the SAOA encompasses all forms of practice modalities in the private sector including independent practice, group practice and franchise models, as well as optometrists employed in the public sector.

2.2. Optometry defined

Optometry is a healthcare profession that is autonomous, educated, and regulated (licensed/registered), and optometrists are the primary healthcare practitioners of the eye and visual system who provide comprehensive eye and vision care, which includes refraction and dispensing, detection/diagnosis and management of disease in the eye, and the rehabilitation of conditions of the visual system.

2.3. Scope of Practice

It is significant to note that the dispensing of optometric materials such as spectacle lenses involves the professions of optometry and dispensing opticianry. Both professions are registered with and regulated by the Health Professions Council of South Africa (HPCSA).

The dispensing of spectacle lenses and contact lenses are regulated via a Scope of Practice which relates to registered competencies as a result of the required education and training. In essence, non-qualified persons may not dispense or sell lenses or contact lenses to members of the public.

2.3.1. **Acts pertaining to the Profession of Optometry**

The following acts are hereby specified as acts which, for the purposes of the Health Professions Act (Act 56 of 1974) which are deemed to be acts pertaining to the profession of optometry:

- The performance of eye examinations on patients with the purpose of detecting visual errors in order to provide clear, comfortable and effective vision; and
- The correction of errors of refraction and related factors by the provision of spectacles, spectacle lenses, spectacle frames and contact lenses, and the maintenance thereof, and the use of scheduled substances as approved by the board and the Medicine Control Council or by any means other than surgical procedures.

The provisions of this regulation do not prohibit the provision of spectacles, spectacle lenses and spectacle frames by a registered dispensing optician on the prescription of a registered and suitably qualified medical practitioner or of a registered optometrist.

It is important to note that the scope of practice for optometry has recently been extended to include specific 'therapeutic' procedures and pharmaceutical substances. In essence optometrists with the required training will be able to treat conditions such as 'Red Eye' and remove foreign bodies.

2.3.2. **Acts pertaining to Profession of Dispensing Optician**

The following acts are hereby specified as acts which, for the purposes of the Act, are deemed to be acts pertaining to the profession of Dispensing Optician:

- The provision, direct to the public, of spectacles, spectacle frames and spectacle lenses designed or intended to correct errors of refraction, including the performance of facial measurements and adjustments; and
- the repair or replacement of spectacles, spectacle frames and spectacle lenses.

2.4. Standards of Care

Optometrists exercise their professional judgement based on the merits of each individual case. The goal is to provide optimal visual acuity at all working distances.

While the above statement is true, optimal vision remains a relative term. It is true that a person may "cope" with a pair of white single vision distance lenses (and near lenses, if over 40 years of age) to a basic plastic frame. However, technical advances in lens design, materials and coatings have made it possible to enhance the quality of vision and provide protection to the eyes. The converse is also true, that not all patients require all the options available since cost becomes a factor. However, prescribing and dispensing spectacle lenses today is about patient expectations and perceptions of comfort, convenience, aesthetics, quality of life and vision. It therefore is incumbent on the optometrist to assimilate all the facts before drawing conclusions as to what is construed as an optimal prescription, yet an effective minimum standard.

2.5. Vision Related Materials

The following represent a brief guideline regarding lens options regarded as acceptable standards of care, by way of example. This is by no means an attempt to cover all available products.

• Polycarbonate, Organic or safety hardened glass lenses for children under the age of 13 years.
• Polycarbonate or Organic lenses are advised for those taking part in contact sport, cycling or motor cycling. (Contact lenses may also be an option.)
• Organic lenses may even be advised for those with sinusitis or sensitivity to heavy spectacles.
• High refractive index glass or plastic may be used in high prescriptions (over minus 6.00 diopters and Plus 4.00 diopters) to allow for thinner lenses with less chromatic and spherical aberrations. Such lenses are further enhanced by the use of anti-reflex coatings.
• Quartz (hard) coating for those who work in dusty conditions while wearing Organic lenses.
• Organic lenses with Quartz coating and UV protection are advised for those who weld and use angle grinders (be it prescription or safety goggles).
• Multifocal or Progressive lenses are now the lens of choice for those over 40 years of age (Presbyopia), due to the extensive use of computers and the need for an intermediate correction. A second pair of reading spectacles is advised in cases where there is an added reading workload, due to the restricted near vision area experienced in multifocals.
• Bifocals are used for those only requiring near (40cm) and far vision, such as administrative personnel, not using computers.
• Protective eyewear is advised in the workplace even when no visual anomaly exists, or with associated risk factors.
• Dentists and those requiring protection from blood or flying debris should wear Plano White CR39 lenses, or full face Perspex if no prescription is evident (emmetropic).
• Light sensitive people, those working outdoors or exposed to high levels of radiation should be wearing lenses with the necessary protection to reduce the risk of: cataract development in later years, pterygiums, macular degeneration and eye strain (asthenopia).

Protection against UV is also required for people with ocular conditions such as Retinitis Pigmentosa, Albinism, Aniridia, Corneal surgery, Post Cataract, Contact Lens Wear and when medication induces photosensitivity.

Sunglasses remain a controversial subject, however, they are not just a fashion statement and Optometrists should be allowed to prescribe these in cases with merit. The Association supports Optometrists prescribing sunglasses, following a comprehensive eye examination and suitable motivation provided for their use.

Contact lenses have also been proven as an effective means of correction and not just simply a cosmetic option. However, these should be worn in conjunction with spectacles which serve to reduce contact lens over wear or when problems such as infection or emergencies arise.

Contact lenses are clinically indicated in cases such as:

• Keratoconus, Penetrating Keratoplasty, Irregular Astigmatism & corneal scarring - to replace the defective cornea and achieve good vision.
• Cosmetic cases such as Eye injuries, Aniridia, Pannus or Microthalmus, where sight is lost. Corneal shells are also used here.
• High Myopia, High Hypermetropia as well as High Anisometropia and Aniseikonia.
• Bandage lenses - post operatively, for administering medication and in severe cases of dry eye.

3. Health Consumerism

Internationally and in SA there is an increasingly strong focus on and move towards health consumerism. This is a movement, which advocates patients' involvement in their own health care decisions. It entails in essence that new health care delivery models encourage greater patient responsibility through the intelligent use of information technology. It encourages health information empowerment and the transfer of knowledge so that patients can be informed and therefore be more involved in the decision-making process. Health consumerism is very strong in the eye care environment. Optometric devices and materials nowadays incorporate many features to enhance the lifestyle of consumers and are designed to support a consumer to participate "normally" in activities of daily living. It is submitted that this should be considered and incorporated in any regulatory programme due to the potential impact on patients.

4. The SAOA Optometric Market

It is important to note that the optometric market is not officially audited. Statistics presented in this submission have been sourced from the Board of Healthcare Funders (BHF), Council for Medical Schemes (CMS - Annual Reports), Health Professions Council of South Africa (HPCSA), suppliers of optometric materials, amongst others.

There are 3200 registered in optometrists in South Africa of whom 2500 are active in practice.

The SA private optometric market is worth R2,3 billion rand which represents approximately 2% of the total private health care market.

The optometric market is distinctively different from most other form of healthcare provision in that optometric practice can be considered a dichotomy as there is professional component as well as a commercial component. The commercial component refers to the provision of spectacles and sunglasses which some regard as fashion items.

Information available indicates the following break- down in turnover (averages), representing the basic services and products provided by optometrists:

- Lenses - 46%
- Frames – 31 %
- Contact lenses – 6%
- Consultations – 17%

The private market comprises primarily 3 forms of practice, namely, the franchise, the group practice and the independent practice. The franchise type models account for approximately 480 stores in the country, broken down as follows:

Specsavers – 280 stores

Torga – 80 stores

Vision Works – 28 stores

Mellins – 70 stores

Other - 22

Independent practice represent the majority of practices at this time.

5. Submissions

5.1. The Designated Service Provider

5.1.1. Introduction

The medical scheme is a major force within the lives of healthcare providers in South Africa including the profession of optometry. The perceived power of medical schemes in 'dictating' services and medical devices to be provided ('benefits') and related costs have resulted in some bewilderment amongst healthcare practitioners as well as members of the public from ethical and legal perspectives.

The proposed oral submission refers primarily to the anti -competitive conduct of designated service providers who operate on behalf of medical schemes on the basis of their abuse of dominance within the optometric managed health care environment under Section 8 (c) or alternatively under Section 8(d) (i) of the Competition Act which significantly impairs competition, alternatively, and in any event, have anti-competitive effects, and have no pro-competitive consequences.

5.1.2. The Medical Scheme Defined

The definition of the business of a medical scheme is found in the Medical Scheme Act and reads as follows:

"Business of a medical scheme" means the business of undertaking liability in return for a premium or contribution-

• To make provision for the obtaining of any relevant health service

• To grant assistance in defraying expenditure incurred in connection with the rendering of any health service;

• Where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.

5.1.3. The Medical Scheme at a Glance

A medical scheme is allowed to be registered in South Africa if it complies with criteria that are set out in the Medical Schemes Act No. 131 of 1998. This ensures that they are financially sound, have sufficient members and do not discriminate against any of its members. Medical schemes are run by a board of trustees, 50% of whom need to be members of the scheme. A person, who is a director or an employee of a medical scheme, may not be a member of the board of trustees of the same medical scheme.

The duties of the Board of Trustees are to appoint a capable Principal Officer; who ensures that the operational records of the scheme are kept accurately and that the scheme has proper systems and controls.

Most importantly the Trustees need to ensure that there is adequate and appropriate information available and communicated to all members. This is information includes the rights, benefits and contributions of members as well as the responsibility of a member within the scheme.

In addition, a medical scheme operates as a 'non-profit organisation (NPO)', previously also known as 'Section 21 Companies'. Simply put, this means that it does not have shareholders, and therefore does not pay dividends or distribute its profits. It has Directors who run the NPO, but they are paid a retainer or a salary for their services.

On a year-to-year basis NPO's may make a profit, but that money must be carried forward to the following year in its entirety, and can only be spent on operational activities of the organisation.

5.1.4. Medical schemes vs. 'Administrators'

Medical schemes may be administered by an intermediary.

This organization must also be accredited. Once accredited, administrators are able to charge schemes for services rendered to the scheme for example, membership management, processing of claims, etc. Administrators are therefore not non-profit companies, unlike the medical scheme and are able to make a profit.

5.1.5. The Council of Medical Schemes

The Council of Medical Schemes (CMS) is loosely described as the 'ombudsman' of the medical aid industry. It is a statutory body established by the Medical Schemes Act to provide regulatory supervision of private health financing through the medical schemes.

The Minister of Health appoints a Board, which then governs the Council. The Executive Head of the Council is the Registrar of Medical Schemes, who is also appointed by the Health Minister in terms of the Medical Schemes Act. The Council determines overall policy, but day-to-day decisions and management of staff are the responsibility of the Registrar and the Executive Managers.

The Council for Medical Schemes therefore supervises a huge and very important industry: The Medical Schemes Act provides the Council with a number of statutory objectives including:

• To protect the interests of medical schemes and their members;

• To monitor the solvency and financial soundness of medical schemes;

• To control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy;

• To investigate complaints and settle disputes in relation to the affairs of medical schemes;

• To collect and disseminate information about private health care in South Africa;

• To make rules (that are in line with the Medical Schemes Act) with regard to its own functions and powers; and

• To make recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes

5.1.6. **Prescribed Minimum Benefits (PMB's)**

270 conditions have been identified as Prescribed Minimum Benefits (PMB) conditions.

25 have been identified as Chronic Disease List (CDL) conditions and algorithm guidelines published.

All PMB costs have to be paid for from the Medical scheme's risk pool.

Standards of care has to be equal to at least the care provided in government hospitals

Patients may have co-payments in certain circumstances

Designated Service Providers (DSP) may be appointed to treat PMB conditions

Health care in South Africa is undergoing an evolution of change. Among the most controversial of these changes, include the emergence of new legislation and managed care.

The approach is likely to change fundamentally the way in which health services are financed and delivered in South Africa. Various micro-management techniques will be employed by managed care to achieve the stated aim: that is to control costs and maintain quality care.

The legislation concerning Prescribed Minimum Benefits will have far reaching effects on the practitioner's ability to provide the clinical standard of care they believe is best for the patient – and in an affordable manner.

5.1.7. Determination of Professional Fees

The medical scheme is regarded as a single consumer of health care and thus has the entitlement to purchase services and products just as any other consumer. Nevertheless, in this capacity, the medical scheme is in a position to dictate levels of service and costs. As result, health care providers are forced to all charge a uniform fee.

Should providers fall outside the boundaries of fees as determined by both medical scheme and/or DSP, there are detrimental consequences for the providers concerned as very often the provider will not be paid directly.

In practical terms, either the patient will need to pay upfront (which is a disincentive, especially for e.g. the purchase of spectacles) or the medical scheme will pay the patient and the provider will need to chase the patient for payment.

Although the medical scheme may represent many thousands of beneficiaries (in some cases, millions) the medical scheme is nevertheless a single consumer. From a completion law point of view, the medical scheme may not collude with other medical schemes regarding costs.

5.1.8. Medical Schemes Act

Interestingly, this Act refers to Designated Service Providers only within the context of Prescribed Minimum Benefits (PMB's).' Participating providers are referred to within the context of all managed health care arrangements.

Regulation 7 defines a DSP as a provider or group of providers 'selected' to provide the diagnosis, treatment and care in respect of one or more PMBs. It makes no mention of any contractual arrangement, processes or negotiation that would precede such 'selection'. In any event, competition law places

restrictions on the extent to which a representative body of, for example, a group of specialist's independent practitioners' association or a health care professionals network could negotiate on behalf of its members as far as fees, and the conditions related to fees, are concerned.

'Participating providers' are preferred providers on the basis of a contract directly between that provider and a medical scheme'. Regulation 15A of the Act stipulated conditions of such contracts.

• The contract must clearly set out the terms, i.e. the responsibilities of each party.

• The provider group must be accredited as a managed healthcare organisation by the Council for Medical Schemes (CMS).

• The scheme is responsible towards its members in relation to the services rendered under the agreement.

• If the agreement entails the limitation of the rights or entitlements of beneficiaries (e.g. protocols, restrictions, etc.), the scheme must provide the CMS with a document clearly stating such limitations, and amendments thereto must be submitted within 30 days of any amendment taking effect, including the relevant amendments.

Recently the CMS has withdrawn the managed care accreditation status of a number of provider groups on the basis that they were not undertaking managed care, and that they were only DSPs. It appears clear that DSP arrangements would be limited to payment arrangements with the professionals, whereas 'participating providers' would refer to arrangements where the professionals play an active role in applying and enforcing scheme managed care provisions.

Of significance is the recent move by medical schemes selecting medical device suppliers as DSPs. In terms of the understanding of the definition of 'providers', DSPs refer to persons and entities that provide healthcare services (as opposed to healthcare goods or supplies). This differentiation between services and goods is also found in the Consumer Protection Act.

To complicate matters further, separate provisions exist for capitation agreements. Capitation is defined where the provider agrees, in exchange for a pre-negotiated fixed fee, to deliver specified benefits to some or all of the members of the medical scheme. Although this implies limitations, these imitations and the rationing of benefits are left to the provider. However, regulation 15F sets the following criteria for these contracts:

• It must be in the interests of the members of the medical scheme.

• There must be a 'genuine transfer of risk' from the scheme to providers (registered as a health care organisation).

• The capitated payment must be 'reasonably commensurate with the extent of the risk transfer'.

The same principles would apply to per diem- and global fees, which all constitute forms of fixed fees.

The regulations to the Medical Schemes Act aim to protect patients against possible negative consequences that could result from managed care arrangements through provider contracts (i.e. by means of capitation- and participating provider arrangements):

• Early termination in cases where the availability or quality of healthcare rendered is likely to be compromised by the continuation of the contract.

• A prohibition on the use of 'any incentive that directly or indirectly compensates or rewards any person for ordering, providing, recommending or approving relevant health services that are medically inappropriate'.

• All information pertaining to the diagnosis, treatment or health of any beneficiary must be treated as confidential, but may be disclosed to the scheme. The scheme, however cannot share that information with any other party.

• Patients should be allowed, without negative consequences the right to complain, lodge an appeal or take legal action even though they are subject to these arrangements.

In certain circumstances, patients are, by law, entitled to visit non-DSPs for PMB conditions. These are in cases where the DSP is not available (or do not render the particular service), where the DSP is too far from the patient's work or home, or where the patient requires immediate attention. In these circumstances the scheme must pay the non-DSP at the rates such entity charges.

It is to be noted, though, that there are many examples where the right of patient choice is relinquished where the patient becomes obligated to consult only those practitioners who are members of the network. Of concern is that there is not always an equitable opportunity for practitioners to participate, such as in the cases of Affinity Health and Agility Health.

5.1.9. The Board of Healthcare Funders (BHF)

The BHF is the representative organisation for the majority of medical schemes in South Africa, Namibia, Botswana, as well as Lesotho.

As the industry representative body, the BHF relies on the membership of medical schemes to ensure that it is able to lobby government and other organisations effectively and to influence policy where necessary on behalf of the industry

'Serving medical schemes' is the BHF motto. BHF members include medical schemes, administrator organisations, and managed care organisations

5.1.10. Practice Code Numbering System (PCNS)

Developed and owned by the Board of Healthcare Funders (BHF), this database is a comprehensive repository of healthcare provider information which boasts 247 healthcare disciplines encompassing a total of 53 247 records of healthcare providers.

In essence, the PCNS provides practice numbers to practitioners to enable reimbursement for professional services rendered and appliances supplied, where applicable.

It is important to note that that the numbering system for the facilitation of claiming by healthcare professionals from medical schemes is awarded by the CMS on the basis of a tender.

Of interest is that the claim numbering system has recently been awarded to another service provider but the BHF has instituted legal action against the CMS which challenges the CMS decision to move the practice code numbering system from the BHF. The SAAA will keep members informed of any developments in this regard.

5.1.11. The BHF Healthcare Forensic Management Unit (FMU)

The FMU is an information and resource sharing group, instituted by the BHF, which involves the participation of medical schemes, administrators, managed care entities as well as insurance companies. The main focus of this unit is the unified approach against fraud in the medical aid environment.

5.1.12. **Medical Schemes: Facts and Figures (2013)**

• Total benefits paid by medical schemes in 2012 increased from R103.3 billion to R112.5 billion in 2013, representing an 8,9% increase.

• The Total number of beneficiaries increased by 1, 08% in 2013 which now stands at 8,776,279.

• The average age beneficiary id 31, 9 years.

• The number of medical schemes decreased from 93 (2012) to 87.

• Discovery Health is the largest medical scheme with 2, 52 million beneficiaries.

5.1.13. **The Designated Service Provider (DSP)**

On 24 March 2013, the Health Professions Council of South Africa published a media release entitled 'Concerns over the exploitation of Health Care Practitioners '. These concerns relate specifically to pressures applied on practitioners to participate in various forms of contracts with medical schemes. Practitioners who feel unduly pressurised or feel their ethics could be compromised were invited to engage with either the HPCSA or in cases where there were perceived transgressions by the medical schemes concerned, the Council for Medical Schemes.

This release follows what appears to be a series of unilateral decisions taken by specific medical schemes such as Discovery Health to institute their own contracting with 'participating 'practitioners in the eye care industry. The term 'unilateral 'is based on the significant differences, in practical terms, between 'consulting 'and 'negotiating '.

'Consult' is misleading as opinions may be solicited but decisions are taken without further negotiation. Negotiation is a process between two or more parties, often with divergent viewpoints, with the aim of achieving a 'win-win 'situation.

Designated Service Providers (DSPs), or preferred (so-called 'participating') providers, are used by funders (not only medical schemes, but also by employers, insurers, and the likes) to provide services to members, or groups of members in terms of some agreement. The intention by the schemes concerned include the provision of increased value to scheme members, reduction in costs and a marketing opportunity to boast savings achieved to members and trustees.

There are a number of legislative and ethical considerations pertaining to the so called designated, participating or preferred provider arrangements, encompassing (eg) the Health Professions Act with related Ethical Rules, the Medical Schemes Act, the Competition Act, the Protection of Personal Information Act (POPI) and the Consumer Protection Act (CPA).

5.1.14. The Platinum Health Model – Example

Platinum Health is registered as a closed medical scheme, with membership being restricted to the employees and dependants of the following participating employer groups:

Anglo American Limited

Anglo American EMEA Shared Services Unit (Pty) Limited

Anglo Platinum Limited

Anooraq Resources

Bafokeng-Rasimone Platinum Mine JV

Bokoni Platinum Mine JV

Modikwa Platinum Mine JV

Mototolo JV

Platinum Health

Platinum Heath was granted a concession by the HPCSA a number of years ago to employ their own healthcare practitioners which include optometrists, audiologists, amongst others, on the basis that the medical scheme was affiliated to the mining industry. The understanding is such concession was granted due to the remoteness of the locations of the mines where access to healthcare is severely restricted.

Platinum Health, however has set up an optometric practice situated in the centre of Rustenburg. employees of Platinum mines and their families are restricted to only consult the Platinum Health employed optometrists.

Considering that an extremely significant proportion of the population of Rustenburg and surrounds are employed by the Platinum Mine groups, this continues to have a detrimental impact on those practitioners who practice in Rustenburg despite the fact that the private practitioners concerned have been prepared to render the same level of service and fees as those of Platinum Health.

In addition, Platinum Health continues to employ registered practitioners which is a violation of the HPCSA Ethical Rules and a matter yet to be resolved by the regulatory body despite the fact that Platinum Health have employed their own practitioners for a number of years. The issue of employment of practitioners and ownership of practices by non-registered parties was a matter recently addressed in Buchanan versus the HPCSA by the Competition Tribunal as well as the Competition Court where the HPCSA Rules in this regard were upheld.

The resultant effect on the market is that there is a lessening of competition in Rustenburg in that practitioners not employed by Platinum Mines may not participate in the scheme's offering of optometric benefits to employees of the mines. In addition, employees of the mines and their families have no choice but to only consult the Platinum Health optometry practice situated in the centre in Rustenburg.

5.1.15. The KFML Model - Example

KFML is a company incorporated in accordance with the laws of South Africa and is the sole shareholder of Specsavers Pty Ltd and PPN. Of significance is that PPN falls within the KFML Holding Company stable together with well- established optometry groups such as Specsavers.

KFML is a dominant firm in the mentioned markets due to PPN and optometric groups which form part of the group.

PPN, by their own admission is the largest optometric Provider Network in South Arica with some 2000 members, all practicing optometrists. PPN owns in excess of 80% (eighty per cent) of the independent preferred provider managed care market.

PPN enters into separate contracts with various medical schemes where PPN agrees to manage the procurement and administration of the optometric benefits of these schemes.

In 2014, PPN contracted with 22 (twenty-two) medical schemes representing approximately 2.5 million beneficiaries. Of these, Bonitas is one of the largest with 700 000 (seven hundred thousand) beneficiaries which has contracted with PPN for approximately 12 years. Despite Bonitas appointing a competitor network, Iso Leso, in 2016 to provide the required services, other acquisitions by PPN, PPN remains dominant in the market.

PPN Providers pay an administration fee which equates to R150-00 (one hundred and fifty rand) for every frame sold. PPN Providers receive frames from PPN at no charge but such frames are not always considered to be of the desired professional quality by practitioners. Therefore, should an optometrist select a preferred non PPN frame, the fee of R150-00 will be deducted from the selling price of the selected frame? This can have a significant negative impact on the viability of sales of spectacles and ultimately the bottom line of practices as there are negotiated eye care packages whereby the medical scheme will pay only R600(six hundred rand) or less. The administration fee of R150 represents 25% (twenty-five per cent) of turnover or more in addition to the practice overheads and cost of sales.

PPN also provides buying group services such as negotiated rebates with laboratories for spectacle lenses, professional indemnity insurance, design and shop-fitting services as well as loyalty programmes to its members.

5.1.15.1. Dominance

• PPN is dominant under Section 7 of the Competition Act in that its market share in the managed care eye care market exceeds 80 % (eight per cent). PPN thus has the market power to act independently of its customers, competitors and/or its suppliers.

• KFML is a dominant firm due to the dominance of PPN and optometric groupings in their respective markets.

The turnovers of PPN exceeds the thresholds promulgated under Section 6 of the Competition Act and in turn, so would the consolidated turnover of KFML

By virtue of its absolute dominance within the optometry market, practicing optometrists are forced to become PPN providers and thus are compelled to provide professional services and spectacles at prices determined by PPN to the beneficiaries of those medical schemes contracted with PPN.

Should practitioners not participate in PPN contracts with medicals schemes which have relevance to those practitioners, there are deleterious consequences in that patients may be forced to seek services from alternative practices which are contracted to PPN.

PPN Providers are forced to:

- Participate in a compulsory PPN Biometric system at a cost.
- Participate in a compulsory PPN tagging system,

5.1.15.2. Inducement

Section 8(d) (i) states that it is prohibited for a dominant firm to require or induce a supplier or customer to not deal with a competitor unless the dominant firm can show that the effects are outweighed by pro-competitive benefits. The following are examples of conduct which can only be regarded as anti-competitive.

The PPN call centre provide the contact details of Specsavers Practices only to members of the public seeking contact details of a PPN provider to the detriment of other PPN providers who are, in fact, competitors of Specsavers practices.

5.1.15.3. **Exclusionary Conduct**

PPN has its own brand of sunglass outlets which trade under the name 'Eye Bar' and are promoted to members of the public as PPN accredited practices.

The majority of these outlets are situated in Specsavers practices

5.1.16. HPCSA Rules and Regulations

It is important to note that health care providers are regulated by the HPCSA, and, as such, are compelled to abide by the HPCSA Rules and Regulations. This also applies to the signing of contracts.

The HPCSA Policy on Business Practices contain various guidelines relating to managed care that would affect the types of arrangements authorised by medical schemes legislation. In this regard the Policy on Undesirable Business Practice makes allowances for credentialing and accreditation of practices as well as the concept of Preferred Provider Arrangements, provided such arrangements are based on:

- Transparency
- Professional qualifications
- Competence of the providers
- Experience of the Providers
- Equitable opportunity to participate.

In essence, health care providers have the right to participate in any preferred provider network agreement if they meet the criteria of professional qualifications, competence and quality of care, but that the networks should not be exclusive, i.e. all providers must have the option of being included 'unless compelling reasons for exclusion exists'.

Of course, all contracts are to comply with existing legislation.

The HPCSA has in the past ruled that it had no objection to a medical scheme notifying its members of preferred provider agreements entered into with specific doctors, provided that, among others:

• All practitioners in the area(s) concerned were informed that they could apply to be preferred providers for the scheme.

• No practitioner was unreasonably excluded from being a preferred provider for that scheme.

• The patient was not deprived of his or her right of freedom of choice of a practitioner, although it may cost the patient more (e.g. by the scheme requiring a co-payment).

Where the provider's recommendations for treatment differ from those of the scheme, the patient should be advised in writing of this fact, and should the patient choose the scheme-recommended treatment, the scheme would be legally liable for the treatment decision.

The HPCSA policy also advises that care should be taken to ensure that providers are not, by means of these types of arrangements, incentivised to under-service patients. The policy sees the same risk of underservicing in capitation arrangements, requiring that both providers and patients should be 'thoroughly informed' about the risks, if any.

Questions have been asked as to the 'ethics' surrounding preferred provider agreements as well as the legitimacy, including the constitutional rights of patients (to choose) and practitioners. In addition, there is the issue of Touting and Canvassing as per the HPCSA Ethical Rules

It is important to note that there are arrangements in South Africa where only providers of a specific group may consult members of a particular medical scheme. Providers who do not belong to the group do not have the opportunity to compete or apply for inclusion in the medical scheme. Such arrangements are referred to as exclusivity arrangements. Affinity Health is but one example which embraces such an approach.

5.1.17. **The Consumer Protection Act (CPA)**

The CPA dictates that medical schemes and healthcare professionals are to provide patients with information on the services they render and related terms and conditions. A patient should therefore know whether the practitioner is part of a preferred provider arrangement or not and understand the implications of a preferred provider or managed care arrangement

5.1.18. **Key Concerns Pertaining to DSP Participation**

- Abuse of dominance needs to be addressed
- Inducement to participate with a competing entity is to be reviewed
- There must be an equitable opportunity for health care providers to participate in a DSP arrangement;
- The health of patients must be uppermost at all times;
- The autonomy and professional discretion of practitioners must be respected;
- The choice of the patient is to be respected;

- A Preferred Provider arrangement should be considered in the literal sense i.e. not exclusivity arrangements

- There should be a reasonable range of choice of product, where applicable, to accommodate the clinical needs of patients;

- Should the list on the DSP product formulary not accommodate the clinical needs of a patient, a facility will need to be in place whereby a practitioner may motivate for a product that falls outside the DSP prescribed list of products;

- Registered practitioners will always be accountable for any advertising instituted by the DSP and thus liable for touting or canvassing arranged by the DSP;

- Should fees for services rendered exceed the agreed DSP benefit, any excess payment must be shown on the claim to the medical scheme concerned (Balanced Billing Not Split Billing). Practitioners should not be compromised if fees exceed the benefit if the patient is willing to pay the difference.

5.1.19. Conclusion

The concept of the Designated Service Provider (DSP) is supported by regulatory authorities such as the Health Professions Council of South Africa (HPCSA) and Council for Medical Schemes (CMS).

Provider Network business models and legal forms differ. In essence, each Provider Network represents a collective of optometrists who, by their participation in a particular Provider Network contract either directly with the medical scheme on the negotiated terms or contract with the Provider Network to provide the services to the beneficiaries and are paid by the Provider Network, who, in turn, receives the negotiated funding from the medical schemes.

The anti -competitive conduct of DSP's is to be noted on the basis of abuse of dominance within the optometric managed health care environment under Section 8 (c) or alternatively under Section 8(d)(i) of the Competition Act which has a significant lessening effect on competition within the optometry market and has no pro-competitive consequences.

5.2. SUMMARY OF ISSUES: HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA) ETHICAL RULES 3 AND 4: ADVERTISING, TOUTING CANVASSING/ INFORMATION ON STATIONARY

This submission refers to the HPCSA Ethical Rules 3 and 4 which relate to advertising, canvassing and touting as well as the ethical rule which addresses information on stationary items.

The Competition Commission, by notice in the Government Gazette of 25 November 2011, announced that it rejected the application from the HPCSA for its Ethical Rules to be exempted from the Competition Act. The specific ethical rules highlighted included advertising, canvassing and touting (Rule 3) and Information on stationery (Rule 4),

5.2.1. The Ethical rules related to *canvassing* and *stationery* were deemed to <u>not</u> be reasonably required to maintain professional standards and that the rules were considered <u>overly restrictive</u>.

5.2.2. . HPCSA registered practitioners, including optometrist are entitled to advertise responsibly but may not tout or canvass. In essence the advertising may not:

- be misleading
- use fear to entice patients
- give guarantees of service
- bring the profession into disrepute

The SAOA supports the principles related to responsible advertising but opposes the absence of a regulatory frame-work to ensure that vague messages do not mislead the public.

5.2.3. **Touting** refers to the enticement of members of the public to practices by using items or services that fall outside the scope of practice as incentives.

5.2.4. C**anvassing** refers to informing members of the public of the attributes and/or qualities of the practices.

5.2.5. The case for responsible advertising is further supported by the following:

5.2.5.1. A free market economy is a necessary condition of prosperity in modern markets. Consumers have to be sufficiently informed to make intelligent choices.

5.2.5.2. To be properly informed, a consumer is reliant on advertising and informed choices are based on information.

5.2.5.3. Advertising, in its broadest sense, is the vital conduit for that information between provider and consumer.

5.2.5.4. Knowledge of available options and the case for each of them makes consumer choice both possible and meaningful. Informed choice promotes consumer freedom.

5.2.5.5. Every freedom requires intellectual consistency. If there is freedom to enjoy religious, political and product choice, there must be a corresponding freedom to explain and expound the choices.

5.2.5.6. Advertising creates and encourages competition.

5.2.5.7. Most importantly a major purpose of the Competition Act is to "ensure that small and medium sized enterprises have an equitable opportunity to compete within the economy". Optometry practices fall into the category of 'small and medium" sized entities.

5.2.6. The SAOA is of the view, however that healthcare practitioners are deserved of special consideration with greater responsibility relating to the welfare of healthcare consumers. In this regard, the position of the SAOA is to institute a regulatory framework to ensure that communication to the public in any shape or form is devoid of misleading potential or exploitation by a vulnerable public.

5.3. Mobile Practices

5.3.1. The SAOA fully supports the position of the Professional Board of Optometry and Dispensing Opticians (PBODO) and Health Professions Council of South Africa (HPSA) regarding standards of practice and adherence to ethical conduct of registered practitioners.

5.3.2. Compliance to such clinical and ethical standards pertains to all forms of practice, including mobile practices.

5.3.3. Furthermore, SAOA also supports the criteria stipulated by the PBODO for the rendering of services via a mobile optometry practice.

5.3.4. However, the application of the ethical guidelines by the PBODO places significant emphasis on whether an area is 'over-serviced' (?) and thus approval by the PBODO to operate a mobile practice is primarily determined on the basis of whether there are established practitioners in the area or not, despite the fact that the mobile practice may conform, if not exceed, the stipulated clinical and ethical standards.

5.3.5. The introduction to the Ethical Rules relating to Vision Screening, Itinerant Practices and Mobile Clinics reads as follows:

> "The ever increasing numbers of practitioners competing for 'businesses within the urban areas has resulted in them experiencing the constraints of over-serviced markets. This has resulted in numerous attempts being made to increase the individual share of the diminishing market and hence sees the introduction of mobile practices and corporate vision screening..."

5.3.6. In addition, the same document includes the following:

5.3.6.1. "It has been noted that mobile units are conducting services in areas that has adequate numbers of practices and hence servicing of already over-serviced areas, exacerbating the neglect of under-serviced areas in the country....." and

5.3.6.2. "Practitioners should at least comply with the following basic rules:

(i) be registered for operations within a defined underserviced area only." .....

5.3.7. The PBODO appears to have no official 'yard stick' to ascertain of what constitutes an 'over serviced' market.

5.3.8. The SAOA is of the view that licensure for Mobile Practice should be based primarily on the standards of operation with appropriate protocols in place to allow for referrals and follow through.

5.4. Deregulation of Practice Ownership

It is to be noted that the SAOA is vehemently opposed to deregulation of practices to allow non-registered parties to own practices and employ registered practices. The recent Buchanan vs HPCSA case refers.

The SAOA position is based on avoidance of commercial influence over professional discretion which has ethical implications.

P MAWILA

SAOA PRESIDENT