THE SOUTH AFRICAN MEDICAL ASSOCIATION

Submission to the Competition Commission Market Inquiry into Private Healthcare

17 November 2014
# Table of Contents

## Introduction
The Functions and Role of SAMA

1.1 Role in the Healthcare Industry 4
1.2 Relationship with members 5

## Part 1: The Participation and Contribution of SAMA to the Private Healthcare Industry

1. The Private Healthcare System 6
2. Pertinent legislation
   2.1 The National Health Act 7
   2.2 The Health Professions Act 9
   2.3 The Medical Schemes Act 9
3. Procedural Coding
   3.1 The SAMA Doctors' Billing Manual 10
   3.2 International Perspective 12
   3.3 The National Pharmaceutical Product Index 13
   3.4 Codes in the DBM 15
   3.5 Additions of or Modifications to codes in the DBM 16
   3.6 The Regulatory Environment 17

## Part 2: The Economic Factors Contributing to Increased Cost of Private Healthcare

1. Healthcare Economics 23
2. A Historical Review of the Progression of Private Healthcare Costs 24
3. Anti-Competitive Behaviour within the private Healthcare Sector
   3.1 Managed Care 33
   3.2 Administrators 34
   3.3 Designated Service Providers and Prescribed Minimum Benefits 36
   3.4 Preferred Provider / Network Contracts 36
   3.5 IPA's and Management Companies 38
   3.6 Hospital Groups and Medical Scheme Administrators 39
   3.7 Reference Price List 40
# Table of Contents

**Part 3: Market Power and Distortions in relation to Healthcare Practitioners**

1. The Absence of Market Power of Healthcare Practitionersé é é .é é é é é é é ...**42**
2. The Costs of Practicing Medicine é é é é é é é é é é é é ...**43**
3. Coding and Tariff Setting é é é é é é é é é é é é é é **44**
4. Concluding Remarks é é é é é é é é é é é é é é é é **44**
Introduction
The South African Medical Association NPC (SAMA) is a non-statutory, professional association for public and private sector medical practitioners. It is registered as an independent, non-profit company. SAMA is also registered as a trade union for its public sector members.

SAMA membership is voluntary, and with over 17 000 public and private sector doctors currently registered as members, SAMA is the single largest representative organisation of doctors in South Africa.

The Functions and Role of The South African Medical Association

1.1 Role in the Healthcare Sector.
The activities of SAMA include the following:
To represent the medical profession with authority and credibility, collectively and individually, in all matters, and to act as the principal co-ordinating and negotiating body for the medical profession,

- serve the needs of members of SAMA to enable them to function optimally as professionals,
- promote health through the expertise and influence of the medical profession,
- take an active part in the promotion of healthcare programs for the benefit of the community,
- regulate relations between its members and employers’ organizations
- to circulate information by means of periodicals and journals, which shall be the property of SAMA, and by the publication of transactions or other papers and documents and by other means of communication.
- To influence the shaping of the healthcare environment.
To maintain the integrity, trust, professional conduct, standards, image, and role of medical doctors.

To promote fair and honourable practice, to discourage or prevent malpractice or professional misconduct, and to ensure the highest clinical, ethical, and scientific standards in the delivery of healthcare.

To provide medical doctors with knowledge relevant to the demands of medical practice through continued medical education.

To promote involvement in medical education, research, and academic excellence.

To develop medical leadership and skills amongst all medical doctors.

To maintain, protect, advance, and extend the honour, interests, and standing of the medical profession.

To grant sums of money from the funds of SAMA for the promotion of the medical and allied sciences in such manner as may from time to time be determined.

1.2 SAMA’s Relationship with its members
Membership in SAMA is entirely voluntary. At no stage does SAMA prescribe to its members how to practice their profession, and in respect of the private healthcare industry, SAMA cannot and does not prescribe to its members on any aspect of the practice of medicine, nor does SAMA issue directives or even guidance to its members on fees to be charged for medical services.
SAMA renders its numerous services to its members throughout the Republic of South Africa.
1. The Private Healthcare System

There are three primary participants in the private healthcare system — firstly, and most importantly, there are the patients who receive medical treatment from medical practitioners. In so doing, they attract a liability to the medical practitioners to pay for the services rendered.

In order to ensure that the patients are not financially crippled by escalating medical costs, they contract with medical schemes who agree to make payment either to them (or on their behalf) to medical practitioners for services rendered, and in accordance with a pre-arranged schedule of benefits contractually concluded between the medical schemes and the patients / members.

The medical schemes either make payment to the patients, or directly to the medical practitioner in respect of the services rendered. Generally, the medical practitioners prefer to be paid directly by the medical schemes, and to recover any excess from the patient.

It is not uncommon for the amounts paid by medical schemes for benefits to be less than what medical practitioners charge therefor and in some cases may even be less than the input costs of providing such benefits. The medical practitioners would then recover the difference from its patients in accordance with the contractual arrangements concluded with the patients. This is known in the industry as "balance billing".

In the result, and in exchange for a monetary premium, a medical scheme therefore assumes liability in respect of the cost of the provision of certain health services to individual members of the public who are its members, as well as their dependant beneficiaries. Yet, the payments are typically made to service providers (including medical practitioners) on behalf of its members.
It is readily apparent that different interests and contractual privities are at stake in the private healthcare system, and they *triangulate* and become complex. In the first instance, there is the arrangement between the medical practitioner and the patient in which the medical practitioner expects (and is entitled) to receive a reasonable remuneration for medical services rendered.

In the second instance, the patient contracts with a medical scheme (to which the medical practitioner is not party) and in terms of which the patient is entitled to expect to be covered at least in respect of part of the fee payable to a medical practitioner or hospital. The Medical Schemes Act (the MSA) makes provision for the payment in full by medical schemes (i.e. without any co-payments or "balance billing") of certain "prescribed minimum benefits" (as defined in the MSA), in certain circumstances.

This system has resulted in intense regulation not only with regard to the quality of professional services which the patient is entitled to expect, but also to accommodate the constitutional imperative of providing healthcare in accordance with designated standards and in regard to the supervision and control of medical schemes. It is only this latter aspect which is the direct remit of the Council for Medical Schemes (the CMS), and under the MSA.

2. Pertinent Legislation

2.1 The National Health Act, 61 of 2003

The National Health Act, 61 of 2003 (the National Health Act) creates the framework for a structured uniform health system within South Africa, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.

The National Health Act recognises that the State must protect, promote and fulfil the rights enshrined in the Bill of Rights, which is the cornerstone of democracy in South Africa. In terms of section 27(2) of the Constitution, the State must take reasonable legislative and other measures within its available resources to achieve the progressive realization of the right of the people of South Africa to have access to healthcare services, including reproductive healthcare.
To this end, the National Health Act regulates national health (in the public and private sectors) and sets out the rights and duties of healthcare providers, health workers, health establishments and users (that is the person who receives treatment or uses a "health service", as defined in the National Health Act). The healthcare provider in this context includes a medical practitioner recognised as such under the Health Professions Act 56 of 1974 (Health Professions Act).

At the apex of the National Health system is the Minister (section 3 of the National Health Act), who is defined to be the cabinet member responsible for health. The Minister is assisted by the National Health Council (as established in section 22(1) of the National Health Act), and the national health policy refers to those policies relating to issues of national health as approved by the Minister.

The National Health Act regulates the basic rights of users and healthcare personnel including the right of the user to have full knowledge of his/her health status (section 6); the necessity to obtain a user’s informed consent for the provision of health services (section 7); and access to health records (section 15) and procedures for the laying of complaints about the manner in which a user was treated at a health establishment and to have the complaint investigated (section 18).

In addition, it is the Director-General of the Department of Health who must ensure the implementation of a national health policy, and issue guidelines for the implementation thereof (section 21). The National Health Council must advise the Minister on targets, priorities, norms and standards relating to the equitable provision and financing of health services (section 23(1)).

Of importance, and in terms of section 90 (1) (u) and (v) of the National Health Act, the Minister may make regulations to provide for the processes of and determination of a reference price list to serve as a non-mandatory guide for the private healthcare industry to determine their fees for services provided. This has occurred in the past with the publication of the National Health Reference Price List (NHRPL”) which we will refer to in greater detail below.
2.2 The Health Professions Act, 56 of 1974

The conduct of the medical profession in executing its business is primarily regulated by the Health Professions Act, and medical practitioners must be registered under this Act. The Health Professions Act provides for the establishment of the Health Professions Council of South Africa (HPCSA) which is the statutory body responsible for regulating the health professions in respect of registration, education, training, professional conduct, ethical behaviour, ensuring continuing professional development and fostering compliance with healthcare standards.

Section 53 of the Health Professions Act empowers relevant professional boards (established under section 15 of the Health Professions Act) to determine the reasonableness of the fees of a medical practitioner. The HPCSA has no regulatory authority over medical schemes. Conversely, the CMS has no regulatory authority over medical practitioners and cannot discipline them or usurp the functions of the HPCSA.

The CMS is not the adjudicator of the reasonableness of fees of a medical practitioner. Its function, in so far as medical fees is concerned, is to address disputes which may exist between medical schemes and their members as to the amounts which are to be paid by medical schemes—not the charges of the medical practitioners, or the manner in which they charge. That is the function of the HPCSA.

2.3 The Medical Schemes Act, 131 of 1998

The CMS is a statutory body established in terms of Chapter 3 of the MSA and its function is to provide regulatory supervision of medical schemes in South Africa. The Registrar is appointed in terms of section 18 of the MSA. Under section 18(2) and section 18(3) of the MSA, the Registrar is the executive officer of the CMS and manages its affairs.

The CMS consists of up to 15 members appointed by the Minister of Health. The Minister of Health also appoints a member of the CMS as chairperson. The executive head of the CMS is the Registrar who is also appointed by the Minister of Health, after consultation with the CMS. As indicated above, the Registrar is responsible for the day-to-day running of the CMS and the management of its staff.

The CMS’s role is the regulatory supervision of medical schemes in South Africa.
The MSA was enacted specifically to provide for supervision and oversight of medical schemes. It conveyed specific powers to the CMS and the Registrar to achieve such purpose. The MSA makes provision for Managed Care Organisations (which will be dealt with in greater detail below) and further to the provision of Prescribed Minimum Benefits (regulation 8 to the MSA). However, both these issues are dealt with in the context of the obligations of medical schemes to make provision for same in their respective scheme rules.

As indicated above, the MSA does not authorise the CMS to set or determine fees that practitioners may charge for health services.

3. Procedural Coding
3.1 The SAMA Doctors’ Billing Manual
The Doctors Billing Manual (DBM) has recently undergone a change of name to the Medical Doctors Coding Manual. However, as the DBM has been known and referred to as such by various role players in the private healthcare industry for more than a decade we will, for the sake of convenience, continue to refer to it as the DBM in this submission.

As already pointed out, the rendering of private healthcare services by medical practitioners is complex and involves a ‘triangulated’ interaction between the medical practitioners, patients (members) and the medical schemes. Billing practices have evolved in order to accommodate the fact that medical practitioners do not always have contractual relationships with the medical schemes, but derive the major portion of their income therefrom by treating patients (members).

Amongst other things the operation of the ‘triangulated’ interaction necessitates the publication of codes to create a common language whereby medical services that are rendered by medical practitioners can be described and identified by standard nomenclature. This coding practice enables medical practitioners to communicate the nature of the medical services rendered to their patients, and those patients’ medical schemes, in a clear and readily understood shorthand way. It is common practice not only in South Africa but globally for codes to be used as contractual descriptions between patients and medical schemes as to the extent and scale of benefits to which the patients are entitled in the various medical schemes.
In the absence of a common language, it would be very difficult and onerous for medical practitioners to describe each and every procedure which they have conducted, and those which are related to it. By way of the easiest of examples, a tonsillectomy would require a page of description as to precisely what medical services are encompassed in performing the surgery for such tonsillectomy, whereas utilising a coding system by two, three or four digit codes that selfsame information can be encapsulated in a single line.

In addition, in the absence of codes there would be variations as to descriptions which would create massive administrative burdens on doctors and medical schemes, and escalate costs unnecessarily. It is also common within the codification to attribute a relative value (which has no relationship to any monetary value) to procedures when measured against each other. The relative value system is based on a scientific procedure whereby the complexity of the procedure, expertise and experience required to perform it and the time involved are taken into account. Accordingly, these units permit very different medical services to be measured by reference to a common metric.

Publication of the DBM is an essential service rendered by SAMA, at considerable expense to itself but provided to the industry at a nominal fee. Members of SAMA obtain access to the publication at preferential rates. SAMA’s revenue is primarily based on subscriptions by members, and the DBM (although an important reach of its operations) is not a major contributor to its income. The publication thereof is seen as a service, and not as an income generating activity. Several thousand copies of the DBM are sold each year, and are available to the public, medical schemes, members and non-members of SAMA and whoever else may wish to acquire insight therein.

SAMA (through its predecessor) first published a form of the DBM in 1944, and has since published it on an annual basis with the exception of 2010.

The DBM has become deeply and inherently ingrained into the system upon which medical practitioners and medical schemes communicate with each other, account for medical services rendered and determine benefit options and cannot possibly be divorced therefrom without abandoning 70 years of development and integration into the healthcare system. Indeed, medical schemes (as a general rule) tend to utilize the descriptors in the DBM to describe the benefit options which they make available to their
members. Of course, medical schemes will each independently determine the amount which will be paid to medical practitioners / members in respect of each of the procedures adopted by such medical schemes from the DBM. It contains the only broad procedural coding system in use throughout the private healthcare industry.

The DBM runs to some 500 pages, and is arranged by reference to various anatomical systems, e.g. cardiovascular, digestive, respiratory, etc.

The more recent versions of the DBM are only published electronically.

The DBM is not only in use in South Africa, but also elsewhere in Southern Africa and specifically in Namibia. SAMA is not the only publisher of a code. The South African Private Practice Practitioners Forum SAPPF, and their health management company (known as Health Man) has its own relatively new code publication. To our knowledge, they have approximately 2,000 to 3,000 members, whereas SAMA has approximately 17,500 members.

The DBM can therefore be described as a coding manual for the healthcare industry and provides a list of procedural codes and associated descriptions that contain relevant data for a range of services relating to medicine, healthcare equipment and supplies, procedures and services so that they can be identified by the medical scheme for it to determine the tariff payable to the medical practitioner in accordance with their specific tariff rules. The DBM furthermore contains guidelines on the interpretation and application of these codes.

3.2 International Perspective
Coding (including the use of modifiers) in the medical industry developed internationally as already pointed out and is a worldwide practice that has been used for many years in healthcare sectors. It entails the use by medical practitioners of uniform codes in order to characterise and circumscribe different clinical interventions based on their scope of practice and for purposes of billing medical schemes or patients for services rendered to patients.

Coding comprises procedural and diagnostic structures which are used to transfer information primarily between healthcare service providers and third party payers (being
medical schemes) in a simplified manner in respect of what diagnosis was made by the healthcare practitioner and procedurally how it was treated. Some countries such as the UK, France, Australia, Canada and the USA have developed their own coding system. South Africa has adopted America’s coding system or structure and has slowly incorporated this in the SAMA structure particularly for the new procedures that are recently adopted and with the view of moving completely over to the American system. At the same time SAMA has continued to adapt the American system to suit the practice conditions in South Africa.

In South Africa, procedural coding is adopted from the American Medical Association’s (AMA) publication, known as the CPT which stands for Current Procedural Terminology (CPT) under a copyright licence held by SAMA and adapted to South African circumstances. SAMA publishes a coding publication entitled “Complete CPT for South Africa (CCSA)” which is mainly used by medical schemes and hospital groups. As medical procedures and technology are dynamic in nature due to new developments in the field submissions are made to SAMA’s coding committee (which reports to SAMA’s Private Practice Unit) by the relevant doctor’s specialist industry bodies for the inclusion of new codes, the modification of existing codes or the deletion of codes for procedures that are no longer performed.

Regarding diagnostic coding, the World Health Organisation has developed a system known as the International Statistical Classification of Diseases and Related Health Problems (ICD-10) which is used in South Africa and throughout the world. This coding structure is updated by various working groups on a global basis and is done so constantly in order to keep up with new medical conditions which are identified.

The use of codes internationally in the medical profession is not only limited to diagnostic processes and procedures. Medicines, surgical and consumable products are covered by the National Pharmaceutical Product Index (NAPPI code as developed by MediKredit in South Africa. It lists and updates items such as medicines, surgical and consumable products imported into and manufactured in South Africa for distribution.

3.3 National Pharmaceutical Product Index (NAPPI) Product Suite
In order to draw a comparison, and for illustrative purposes, we include a brief
A globally unique national coding system, owned by MediKredit, for all pharmaceutical, surgical and healthcare consumable products in RSA, NAPPI codes enable the provider to claim for products via a unique, scheme-recognised, code.

MediKredit has over the years undertaken to facilitate the adoption of NAPPI (National Pharmaceutical Product Interface) as a national electronic standard on behalf of the South African healthcare industry.

A NAPPI code is a unique identifier for a given ethical, surgical or consumable product which enables electronic transfer of information throughout the healthcare delivery chain. Tariff codes, on the other hand, are used as the standard for electronic information exchange for procedure and consultation claims.

MediKredit, as an independent player in the healthcare industry that is not owned by either providers or funders of healthcare, is responsible for the day-to-day management and maintenance of the NAPPI Product File.

MediKredit is also responsible for the implementation of decisions of the NAPPI Advisory Board ("NAB"), an independent, not-for-profit organisation, which consists of healthcare industry role-players. NAB members include hospitals, medical schemes, medical scheme administrators, medical and dental associations as well as other representative industry bodies.

NAB meets on a regular basis to set policies to meet the following objectives:

- to promote and ensure ongoing use in the South African healthcare industry of NAPPI codes as a coding standard for ethical, surgical and consumable products; and
- to improve data accuracy, integrity and completeness thus improving data quality relating to the allocation of NAPPI codes for ethical, surgical and consumable products.

The allocation of a NAPPI code by MediKredit does however not serve as an
endorsement or accreditation of the product in question by MediKredit nor is it a
guarantee of reimbursement of any given product by a funder.
MediKredit, as custodians of the NAPPI Product File, has made a commitment to publish
the public domain file free of charge since the inception of NAPPI as a coding standard.
The public domain file contains information on the NAPPI code, product description,
strength, pack size and manufacturer.

3.4 Codes in the DBM
Coding, in its different iterations, is imperative in the medical industry for purposes of
facilitating the transfer of standardised information relating to diagnosis, treatment and
billing.

The procedural coding incorporated into the DBM comprises three elements. These
elements are as follows:
- a unique four digit numerical code assigned by SAMA;
- a descriptor which describes the professional medical service rendered. This is a
  clinical function requiring input from clinicians and therefore medical practitioners
determine the scope of the work to be included under a particular code; and
- relative value units.

The descriptor is specific for South African practice, but cross-referenced to the AMA’s
CPT descriptors. The DBM RVUs are proportionally related to the unit values assigned
to the CPT codes in the USA. The CPT schedule is based on a resource-based relative
value scale (RBRVS) initially researched by Harvard university. In the RBRVS system,
payments for services are determined by the resource costs needed to provide them.
Annual updates to the physician work relative values are based on recommendations
from a committee involving the AMA and national medical specialty societies. The
AMA/Specialty Society RVS Update Committee (RUC) makes recommendations to
Medicare/Medicaid on the relative values to be assigned to new or revised codes
in Current Procedural Terminology (CPT®). Nearly 8,000 procedure codes are defined in
CPT, and the relative values in the RBRVS were originally developed to correspond to
the procedure definitions in CPT. Changes in CPT necessitate annual updates to the
RBRVS for the new and revised codes.
The DBM also contains modifiers and billing rules as well as interpretations to the basic procedural codes to encourage uniformity, but also provide for special circumstances.

In addition to the above, the DBM publishes for reference purposes the Scale of Fees for Compensation for Occupational Injuries and Diseases Act, 130 of 1993 and the Road Accident Fund Tariffs for emergency care. This Scale of Fees are published in the Government Gazette and are therefore publicly available. Up until 2009, it also included the National Health Reference Price List as published by the Department of Health.

The relevant medical practitioner unilaterally determines the fee to be charged for the medical service rendered taking into account, inter alia, his costs, consumables and products used, market supply and demand, and determines what he regards as appropriate in the context of the descriptor and the value units to determine the fee that he will charge.

The DBM does not, therefore, constitute a tariff or a fixing of price, but rather a code which creates a common language, standardization of description and an assessment of the complexity of medical procedures. The objective scientific nature of the Relative Value Unit allows a rational distinction between the relativities inherent in each medical procedure.

Prior to 2004, the SAMA publication entitled “Benchmark Guide to Fees for Medical Services” a predecessor to the DBM contained a guideline rand amount for different medical procedures as described, but SAMA no longer publishes Rand values in terms of the consent order concluded with the Commission before the Tribunal, as explained below.

3.5 Additions of or modifications to codes in the DBM

It is common for specialist associations representing various medical disciplines, to make representations to SAMA in the prescribed manner as to useful additions to the coding system, and if SAMA approves an application for an addition or an amendment to the DBM, it will effect it. Sometimes general practitioners negotiate directly with medical schemes, and their proposals are incorporated into the medical scheme benefits and never find their way into the DBM. In fact, some of the medical schemes prefer to negotiate directly with specialist associations, and arrange benefits and payment scales
with them (for some or all of the benefit options or plans offered by the medical scheme in question).

The DBM is not static, and is in a state of continual development. Experience has shown that existent descriptors sometimes require supplementation, e.g. where the existent description does not adequately cover complications which could arise. In these circumstances, SAMA includes a modifier to an existent procedure description in the DBM.

The usual way in which a modifier or new descriptor arises is that a formal application is made to SAMA by a representative group of a particular speciality which motivates for the inclusion of such modifier, or a new descriptive procedure in the DBM. SAMA then holds a formal meeting of its coding committee, and if it is satisfied therewith, inter alia, by comparison to the CPT system (as utilized by the AMA) it will accept the new description or modifier and incorporate it into the next publication of the DBM.

If SAMA considers that the proposed description requires amendment, for instance to ensure it is applicable to South African conditions or medical practices, it will effect the necessary amendment. SAMA does not engage with the medical schemes or any representative body of medical schemes to secure their prior consent or approval to any amendment to the DBM.

It is important to note that regulation 5 of the general regulations promulgated under the MSA, and which regulates the content of accounts rendered by suppliers of medical services provides that such account or statement must contain the relevant diagnostic and such other item code numbers that relate to such relevant health service. In addition, regulation 5(j)(iii) of such general regulations provide that where an account or statement rendered by the supplier of medical services makes reference to the use of a theatre, such account or statement must contain all procedures carried out together with the relevant item code number contemplated in regulation 5(f).

3.6 The Regulatory Environment

There is a complex history of price regulation within the healthcare industry, and a current regulatory vacuum which has created dissatisfaction and concern with certain market participants.
To explain the complexity of the regulation, and the current "vacuum" and uncertainty it is necessary to provide a brief regulatory history.

Historically, price determination in the private healthcare industry was regulated by statute. Prior to 1993, the private healthcare industry was, \textit{inter alia}, regulated under the Health Professions Act (and its regulations) and the Medical Schemes Act of 1967. The regulations to the Health Professions Act covered many aspects of the private healthcare industry, including healthcare tariffs charged by medical providers and reimbursement tariffs for medical schemes.

The reimbursement tariffs of medical schemes were determined collectively by medical schemes under the Representative Association of Medical Schemes (\textit{RAMS}, which had a statutory mandate under the Medical Schemes Act No. 72 of 1967 and its regulations to negotiate a set of tariffs which was published annually in the Government Gazette. These tariffs were binding on medical schemes.

As a consequence of amendments to the Medical Schemes Act no 72 of 1967 in 1993, tariffs could no longer be determined by medical associations (created under the Medical Schemes Act of 1967) thus effectively removing any explicit regulatory framework for the determination of tariffs. However, the publication of healthcare tariffs by medical schemes and health provider associations continued as a standard practice. RAMS lost its mandate to determine reimbursement tariffs and became the Board of Healthcare Funders (\textit{BHF}).

The BHF is a voluntary, non-profit organisation which represents the interests of medical schemes in the industry. As part of its functions, it took over the determination of the reimbursement tariffs; however, it did not have a statutory mandate to determine these tariffs. In essence, there were two fee schedules one private and the other statutory (the RAMS or medical aid rate). Medical practitioners had to choose between the two. The election process was voluntary and largely dictated by the economic conditions of the communities medical practitioners served.

These tariffs were determined as a result of a collective bargaining process between the BHF, Hospital Association of South Africa ("\textit{HASA}"), The South African Dental
Association ("SADA") and SAMA, which at that time was known as the MASA. Like the BHF, HASA, SADA and MASA were non-profit organisations which did not have a statutory mandate to determine fees after 1993, and the suggested guideline tariffs were not binding on medical schemes and healthcare practitioners/providers.

MASA (and subsequently SAMA) published these negotiated tariffs for its members in the publication entitled Benchmark Guide to Fees for Medical Services. As is recorded in the SAMA consent order concluded with the Commission during February 2004, the Benchmark Guide to Fees for Medical Services was not a list of enforceable prices and merely served as a guideline for the medical profession, the HPCSA and the Courts, as to the reasonableness of a charge for a particular service. It is recorded further that the HPCSA, as well as the Courts, have used this recommended list of tariffs to discharge its duties in terms of the Health Professions Act, No. 56 of 1974 in matters before the Courts.

HASA is a voluntary, non-profit organisation which represents the interests of private hospitals in South Africa. After 1993, HASA too published a tariff guideline in respect of prices charged to patients for services rendered to them by its hospital members. Like the BHF and MASA, it did not have a statutory mandate to do so.

During the early 2000s, the Competition Commission ("Commission") became concerned about collusion in the healthcare industry regarding the manner in which fees were determined. After an investigation into this issue, The Commission was of the view that the centralised reference price schedules produced by the BHF, SAMA and HASA respectively contravened section 4(1)(b)(i) of the Competition Act No 89 of 1998 ("Competition Act").

Pursuant to the Commission’s findings, during 2004 and 2005 the BHF, SAMA, and HASA entered into consent agreements or settlement agreements with the Commission under section 49D(1) of the Competition Act. These consent agreements were made orders by the Tribunal and the respective associations paid administrative penalties or settlement amounts and undertook to cease publishing tariffs.

In terms of the consent agreement entered into between SAMA, its members and the Commission, SAMA undertook, inter alia, to cease to:
- determine recommend and/or publish tariffs to its members; and
- engage in any conduct which directly or indirectly facilitates an agreement between its members on prices.

In that consent agreement, SAMA recorded, amongst other things, that while it had indicated that it would no longer continue to publish Rand values together with the codes, descriptors and units of medical services, it would continue to advise its members on conducting their practices ethically.

2003 was therefore the last year during which SAMA published suggested rand values for medical services rendered for the benefit of its members.

As a result of the consent agreements that were entered into between the Commission with each of HASA, the BHF and SAMA, a "regulatory vacuum" existed in respect of the prices charged by medical practitioners and hospitals and the reimbursement fees paid by medical schemes. Medical practitioners were accordingly expected to negotiate their fees individually with medical schemes which created an increased administrative burden and uncertainty in the market.

This prompted the CMS to intervene and publish what was called a National Health Reference Price List (NHRPL) for 2004.

Unlike the DBM, the NHRPL contains specific fees designated in rands for each procedural code, but many of the descriptions and value attributions employed by it are identical to those contained in the DBM, or are based upon it. Incidentally, the NHRPL utilizes the SAMA procedural coding system as contained in the DBM. This was done with SAMA's consent and no fee was levied by SAMA for the use of this coding system.

The CMS again published an NHRPL for 2005, but during the course of that year embarked upon a process of ensuring that future NHRPLs would be based upon the actual cost of rendering services and performing procedures. This process culminated into the publication of Circular 69 of 2005 in which the methodologies for the calculation of these costs and the processes for making submissions to the NHRPL process were outlined.
Toward the end of 2006 the NHRPL process was taken over [from the CMS] by the Department of Health and the final regulations to the National Health Act with respect to a National Reference Price List ("NRPL") were published during July 2007.

As with CMS Circular 69 of 2005, the regulations to the National Health Act provided extensive instructions and guidelines with respect to the collection of data, the calculation of the costs associated with the various items in the NRPL and the format in which requests for changes or additions to the NRPL should be made. In other words, the said regulations focused heavily on the process of determining prices, but ostensibly assumed that the items to which the prices were to be allocated existed, were useable and that merely isolated changes and/or deletions would be required from one year to the next.

These regulations resulted in a significant and robust debate within, at least, the private healthcare industry.

A further side-effect of these legislative developments had been that communication between the healthcare service providers and the funding industry had, apart from interactions between specific groups of service providers and individual medical schemes and/or their administrators, became almost non-existent. The resulting dilemma is that, while the clear intent of the legislative changes had been to regulate the process of determining and publishing of a National Reference Price List, there is no consensus on the coding structures or systems upon which the pricing regulations have been based.

The Department of Health published the NRPL in 2007, 2008 and 2009 using the 2006 NHRPL as a basis and made annual inflationary adjustments thereto.

During the process of the compilation of the NHRPL, and whilst debate ensued around the process and the verification of some of the cost studies that had been prepared, a challenge was brought in 2010 by a number of industry participants in the High Court which sought to review and set aside certain regulations published by the Department of Health. In the decision of The Hospital Association of South Africa Limited v the Minister of Health and Others (2011 (1) All SA 47 (GNP)), the High Court declared invalid and set aside on review certain regulations published by the Department of Health in respect of
the NRPL. The reasons for the Court's decision were, amongst other things, that the process followed by the Department of Health in the promulgation of the regulations had been flawed. We will refer to in greater detail to this decision below.

As a result of that decision by the above Honourable Court, certain medical schemes and medical practitioners reverted to using the 2006 RPL as published by the CMS as a pricing and coding benchmark taking into account annual inflationary adjustments, while the healthcare practitioners continued to negotiate their fees with the medical schemes.

In addition to the price lists discussed above, from 2004 the HPCSA began publishing a list of fees or guidelines known as the Health Professions Council Ethical Tariff for Medical Practitioners purportedly under section 53(3)(d) of the Health Professions Act. The purpose of this guideline was that where medical practitioners charged fees in excess of the tariffs published by the HPCSA without the consent of their patients, it was regarded as overcharging unless the medical practitioner had a prior agreement with the patient in question regarding fees or could demonstrate why it should not be regarded as overcharging. As with the NHRPL, this "ethical tariff" utilised SAMA's procedural coding system as contained in the DBM. Again this was done with the consent of SAMA, who charged no fee for the use of its procedural coding system.

During 2008, the HPCSA withdrew this tariff list and cited in a press release the following reasons for doing so:

“...the Department of Health’s new processes around the NHRPL which embraces all healthcare players within the country, eliminates the need to determine our own tariff which has historically been three times higher than the NHRPL.”

“This decision follows the establishment of a new national Health Reference Price List (NHRPL) by the Department of Health including an extensive consultative process with stakeholders, as well as healthcare practitioners”.

To our knowledge, the extensive consultative process referred to in that press release never took place, at least not with SAMA, an important role player.

In view of the above, there is currently no regulatory regime in place in respect of the determination of fees charged by medical practitioners save for the Single Exit Price legislation which is applicable to medicines.
1. Healthcare Economics

Health economists postulate that in a well functioning, perfectly competitive market, consumers will use medical care until the marginal benefits, measured through the demand curve, equal the marginal costs, which in equilibrium will equal the price. In other words people will only access their health benefits when they are sick.

Economists claim that consumers purchase health insurance to offset the risk of becoming ill. This demand for health determines how much a consumer is prepared to pay for it; within a cost threshold beyond which this same consumer’s utility of wealth overcomes their aversion to risk, thereby making the premiums unacceptable and therefore unaffordable. Furthermore, according to the law of “diminishing marginal utility”, the marginal benefits of purchasing health insurance will decline when the consumer is well, because he or she does not experience the benefits of their contributions and paying for their healthcare then becomes what is referred to as a grudge purchase.

There are of course a myriad conditions or illnesses that may befall the unsuspecting consumer at any given time. Unfortunately no consumer possess all the information required to make an informed decision, implying that they will therefore pay any premium imposed upon them by their health insurer, who due to the “asymmetric information” principle, possesses more information and will price at a level that benefits the health insurer, not the consumer nor the doctor.

Economists also propose that the pooling of risk reduces the marginal cost of a service resulting in increased usage thereof and called this phenomenon “moral hazard”. In simple terms it means that someone who is not paying directly for a service is unaware of its cost and then over utilises it. This perceived generosity of payment by the a third
party funder furthermore leads to a relatively inelastic supply curve and allows the supplier or doctor to charge more, once again increasing prices. Economists postulated that patients overused their medical benefits and that doctors overcharged the medical schemes thereby fuelling healthcare inflation, which really took off in the 1990s, and is theoretically why managed healthcare was born, in order to curtail this apparent abuse of the system.

Economic theory however also states that the nature of all companies is to price at the maximum level that consumers will tolerate in order to maximise their profits. The health economic inference is therefore that healthcare inflation is driven by: uncertainty, the fear of sickness and the corporate utility of healthcare companies. Healthcare inflation is therefore by implication not driven by the actual costs of providing healthcare, giving credence to the theory that for-profit healthcare businesses will not reduce the cost of healthcare, but actually increase it.

When considering healthcare economics, one must combine healthcare supply and demand theories with risk, moral hazard and asymmetrical information. The purchase of healthcare also has short and long term decision making implications that do not follow normal economic theory since many of the purchase decisions occur in the absence of perfect information and appear to be irrational. For a market to be perfectly competitive there must be free entry and exit, perfect information, a homogenous product and numerous buyers and sellers each with no power over price.

Given that none of the previously mentioned conditions exist in the private healthcare industry, suggests that this industry is not a perfectly competitive market and when combined with the effects of uncertainty and externalities it becomes a very inefficient market.

2. A Historical Review of the Progression of Private Healthcare Costs in South Africa

As is the case with Consumer Price Index (CPI) inflation, healthcare inflation must be considered from the perspective of the consumer, or in the healthcare context the patient. The most effective way of calculating healthcare inflation is by considering the increase in medical scheme contributions by consumers. To this end all the data used in the following documentary is derived from a retrospective meta-analysis of the Council
for Medical Schemes (CMS) Annual reports from 1981 to 2012. These annual reports are produced by the CMS and contains audited financial information supplied by medical schemes. It is in the public domain and available from the CMS website (www.medicalschemes.com). Due to the fact that the CMS annual reports can only be produced retrospectively, the latest available information is for 2013 as contained in the 2013 annual report.

Medical Scheme Contribution Inflation

Graph 1

Graph 1 tracks the progress of medical scheme gross contribution income (GCI) inflation from 1981 to 2013 in comparison with the corresponding CPI inflation. In 1981 medical scheme consumers contributed R11.73 per beneficiary per month (pbpm). If that value is inflated by the CPI inflation of the intervening years, then consumers should have been paying R196.99 pbpm by 2013 for health insurance. In reality they were paying R1049.51 pbpm, which is 627% higher than the CPI inflated number. For a long time the misconception was that doctors were the cause of this phenomenon. Medical scheme administrators therefore held forth the rationale that in order to attempt to control medical
scheme inflation they imported from the USA early in the 1990s and implemented a concept called Managed Healthcare (MHC).

This did not only fail to bring down medical scheme inflation but in fact became another significant component of the healthcare value chain which in its own right contributed significantly to escalating non-healthcare costs because in order to prevent patients from accessing doctors or medication these companies charged for their interventions.

Graph 2
The upward price pressure of administrators and managed healthcare is demonstrated by graph 2. Despite the absence of sophisticated information technology to assist administrative processes during the late 1980s and early 1990s the non-healthcare component of medical scheme expenditure never exceeded 6.2% of GCI. From 1997, however, there was an exponential increase in non-healthcare costs which crested the 10% barrier in 1999 and has never receded below double figures since then. To place this in context one has to remember that during the 1980s all medical scheme claims were paper based, and administrators employed manual claims processing systems. Today administrators employ extremely powerful IT systems that electronically administer claims and payments, without user intervention which should bring down
costs. The fact that it has driven up costs means that it has in turn become a source of income for the administrators.

Medical schemes may be non-profit companies, but administrators are for-profit businesses and their profits are generated by performing as many transactions or interventions as possible. This is supported by economic theory that for-profit businesses will not reduce costs but strive to increase them in drive for greater profitability for their shareholders.

Graph 3

As is evident from graph 3, non healthcare costs represent R124.53 of the 2013 CGI of R1 235.80 pbpm which is R224% higher than the fees paid to General Practitioners. Specialists who are being depicted as the largest drivers of healthcare costs in turn only receive R209.29 pbpm which is 63% less than the R332.47 that is being paid to private hospitals.
By 2013 medical schemes were spending over R14 Billion or 12.7% of contribution income on non-healthcare costs which are defined by the CMS as:

- Administration fees
- Managed healthcare costs
- Broker fees
- Impaired receivables (bad debt)
- Reinsurance losses or gains

**Brokers**

Prior to 2000, brokers were not allowed to sell medical scheme products and that in 1993; 17.4% of the South African population belonged to a medical scheme. When brokers started selling medical scheme products in 2000, only 16% of all South Africans belonged to a medical scheme, and despite spending R10.2 billion since then, only 16.6% of the population belonged to a medical scheme by 2013. Graph 5 proves that this is exactly the same ratio of the population who had health insurance in 1998 and which proves that despite consuming R10.2 billion of consumers medical scheme contributions, brokers contributed no new members.
Yet medical schemes use brokers to attract members, not by enrolling previously uninsured members, but by poaching members form other medical schemes. This is achieved by promoting non-healthcare related benefits, such as free gym membership, cheaper movie tickets, reduced travel costs or discounts from retailers.

Graph 5

Medical Scheme Administrators and Managed Healthcare

The most substantial non-healthcare costs are administration and managed healthcare. These costs will be reviewed together because it is very difficult to distinguish between the two. This fact is corroborated by the Registrar of the Council for Medical Schemes (CMS) in his 2009/2010 Annual Report (p214) that states: “Administrators and businesses associated with administrators often provide managed healthcare services. In many instances, these services are merely additional layers of administration costs with questionable benefits for the schemes themselves.”
Graph 6

Graph 6 was designed to negate the effect of membership number fluctuations by calculating the percentage increase per beneficiary per year (PBPY) of medical schemes expenditure on their major expenses and compared to CPI inflation (purple bars). This serves to prove which components of scheme expenditure are in reality contributing to increases in beneficiary contributions (GCI Inflation represented by the blue bars):

- From 1998 to 2013, managed healthcare inflation (orange bars) far outpaced CPI inflation almost every year except for 2002 and 2007. The average annual increase in managed healthcare costs from 1998 to 2011 was 23.3% which was 288% higher than the corresponding average CPI.

- From 1998 to 2005 administration costs (red bars) escalated at a far greater rate than CPI inflation every year before active intervention by the CMS in the latter half of the 2000s brought it to a stop. The average increase of administration costs of 14.2% for the first decade of the 21st century was however 136% greater than the average inflation.

- What is also interesting to note is that despite all the money that was being spent on managed healthcare, total healthcare expenditure (green bars) also outpaced CPI inflation on most years from 1998 to 2013. This appears to substantiate the
argument for the implementation of managed healthcare interventions, but which also supports the contradictory argument that managed healthcare is ineffective.

A very important concept to understand is that consumers' personal medical savings account (PMSA) contributions are by law not allowed to be incorporated into a medical schemes' risk pool. Schemes take advantage of this fact by allocating as much of a consumer’s expenses to their PMSA as possible in order to protect their risk pool funds. Furthermore, neither Schemes nor administrators are allowed to use consumers' PMSA funds for administrative expenses. Graph 7 reflects the percentage of medical scheme risk pool expenditure that is consumed by a specific expense. Graph 7 is unique in that it appropriately allocates non-healthcare expenses as a percentage of risk pool expenditure.

Graph 7

Hospitals
The primary reason for the failure of managed healthcare to bring down healthcare costs is that hospitals function largely beyond the reach of managed healthcare intervention since the oligopoly of the three dominant hospital groups in South Africa has such
market dominance that they can force their own terms upon medical schemes and ignore any attempts by schemes to manage costs. Should a scheme refuse to accept a hospital’s group terms or tariffs, that scheme’s members/ consumers will be denied access to the specific group’s hospitals which is not only a public relations disaster for the scheme but has dire consequences for the consumer.

Proof of the fact that hospitals are untouchable is that despite coming off a high base they have swollen their market share by 22%; from 29% in 1997 to 34.2% by 2013. In the process hospitals have become the single largest consumer of medical scheme benefits and by far the largest driver of healthcare costs. The hospital costs reflected in this graph exclude doctor costs.

*Allied Healthcare Professionals*

Significant gains have been made by allied health professionals whose consumption of scheme funds was so negligible that it was not even reflected in 1997 but by 2013 they consumed more resources than General Practitioners. This was caused by managed healthcare companies redirecting patients away from doctors to the allied healthcare professions.

*Dentists*

Dentists have lost 70% market share from 6% to 1.8%.

*Specialists*

Specialists have been maligned in the medical and lay press for being the major cause of healthcare inflation, but have only gained 10% market share from 18.3% to 20.3% from 1997 to 2013 (including radiology and pathology costs) thereby disproving these allegations.

When one removes radiology and pathology costs then specialists represent 12.7% of medical scheme risk pool expenditure and consumed R12.2 Billion rand in 2011, which is almost exactly the same as the R12.1 Billion rand spent on non-healthcare expenses by medical schemes.

*General Practitioners*
GPs have lost a significant 38% market share from 9.2% to 5.6%. But despite this fact, almost all managed healthcare interventions are aimed at restricting patient visits to general practitioners. When one considers that according to the CMS medical schemes paid GPs R5.3 Billion from their risk pool in 2011 but spent double that; 10.6 Billion on administration and managed care, then the question that begs to be answered is whether consumers are purchasing health insurance to fund the administration industry or for healthcare?

*Non-healthcare Expenses*

The biggest beneficiary however of medical scheme risk pool expenditure is however non-healthcare overheads which grew by 68% from 7.5% to 12.6%, meaning that in 2013 schemes spent R14.1 Billion on not providing healthcare to their members.

**Conclusion:**

These figures prove that it is not doctors who are driving up healthcare costs; it is in reality hospitals, allied health professionals and non-healthcare costs that together consume 54% of risk pool funds. General Practitioners and Specialists, excluding radiology and pathology, only represent 18.3% of medical scheme risk pool expenditure, despite being the only component within the entire healthcare industry that accepts all the clinical risk.

3. **Anti Competitive Behaviour within Private Healthcare Sector**

3.1 **Managed Care**

The function of Managed healthcare companies is to advise their client medical schemes on certain aspects of running their businesses such as:

a) They recommend the tariffs that schemes should charge,

b) The design of their benefit options,

c) The criteria for risk pool reimbursement,

d) The medicines that they should pay for,

e) The provider groupings that they must contract with etc.

Managed care companies impact upon all medical scheme members as confirmed by the Council for Medical Schemes which confirms that 98.8% of all medical scheme members were affected by managed healthcare interventions in 2011. Managed
healthcare companies are in a strong position to directly influence medical scheme tariffs.

One of their means of managing the costs of a scheme is to enter into preferred provider (PP) or designated service provider (DSP) contracts with doctors. These contracts dictate the tariff that a contacted doctor is allowed to charge and they use regulation 8 of the medical Schemes Act as their defence. There is overwhelming evidence that managed care companies negotiate exactly the same tariffs for different schemes which is anti-competitive.

3.2 Administrators

Medical scheme administration is a lucrative enterprise which is confirmed by the fact that many of the biggest financial services companies in South Africa such as; Discovery, Momentum, Metropolitan and Old Mutual all have medical scheme administration divisions. None of these massive companies are in the habit of losing money, nor do they get involved businesses that do not generate a return on their investment, and this alone should provide an indication of how profitable the third party medical scheme administration industry is.

According to the Status Medical Administrators Website (www.status.co.za), the function of a Medical Scheme Administrator is to collect and reconcile member contributions, keep membership records, and pay member claims. They also offer and provide other ad hoc services such as; marketing, financial controls, client liaison services, risk management controls and managed healthcare services. But in a nutshell, the function of a medical scheme administrator is to keep member records up to date, collect members’ contributions and pay accounts for and on behalf of a medical scheme. Legally a medical scheme administrator needs to be registered with the Council for Medical Schemes before it can contract with a medical scheme.

It is also common knowledge that almost all administrators also offer managed healthcare services to their member schemes, but often do not list this income separately from their administration income. The registrar of the Council for Medical Schemes had the following to say about this: (2011/2012 Annual Report; p154)

"Managed healthcare services are often provided by administrators or businesses associated with administrators. In many instances, these services are merely additional..."
layers of administration costs with questionable benefits for the schemes themselves; we included them in the “fees paid to administrators” figures where they were paid to the administrator or to any company in the administrator group”.

This raises the suspicion that administrators often charge unnecessary fees in order to boost their income. Although certain medical schemes are self administered, most other medical schemes contract external administrators who in turn can and do administer a numerous, independent medical schemes.

<table>
<thead>
<tr>
<th></th>
<th>Open Schemes</th>
<th>Restricted Schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Administration fees</td>
<td>R1 314 PBPY</td>
<td>R683 PBPY</td>
</tr>
</tbody>
</table>

The table above, reflects the average 2011 administration expenditure by schemes.

What drives such massive administration costs? By law medical schemes are non-profit organisations and cannot list on the securities exchange. Administrators on the other hand are allowed to function as for-profit organisations and therefore can list and generate an income for their shareholders. The reason however that the cost of administering restricted schemes is much lower than that of open schemes, is that restricted schemes are under much tighter financial management from their trustees, because most restricted schemes are single employer schemes, and it is therefore in the best interests of the employer to keep costs at a minimum, because they are in effect financing the running of the entire scheme.

Open medical schemes are also non-profit organisations, but certain self administered open medical schemes used the fact that administrators can return a profit as a loophole to make money for their investors. The means by which this arrangement is reached is that they separate their administrator from their medical scheme and establish it as an independent company. The scheme then contract this newly created “independent” administrator at a higher tariff than what the actual administration costs are. The difference between the actual administration costs and the income that the administrator receives is now pure profit for their investors. This relationship is virtually impenetrable and therefore anticompetitive because there is no chance that the trustees of the scheme can request competitive bids from other administrators.

Administrators that administer more than one scheme negotiate tariffs with doctors on behalf of all their member schemes. An investigation into the tariffs that these schemes
pay doctors will show that they are almost exactly the same, which is by definition anticompetitive.

3.3 Designated Service Providers and Prescribed Minimum Benefits

The Medical Schemes Act is a legislated prescribed scope and level of minimum benefits for members of medical schemes. In terms of the Medical Schemes Act (and in specific the Regulations thereto) any benefit option offered by a medical scheme, must pay in full without co-payment or the use of deductions the diagnosis, treatment and care costs of the prescribed minimum benefits ("PMBs"). PMBs include certain chronic conditions.

The MSA Regulations provide for the appointment by medical schemes of a Designated Service Provider (DSP) to provide the diagnosis, treatment and care of patients with PMB conditions. The Regulations further provide for the imposition of a co-payment or other form of contribution by a member of a medical scheme who chooses not to make use of the services of the appointed DSP.

Notwithstanding the fact that Regulation 8 to the MSA provides that medical schemes must pay in full for the costs of the diagnosis, treatment and care of PMB conditions, the vast majority of schemes offer to pay for such PMS conditions according to scheme rate and not in full as prescribed by the Regulations. This scheme rate is determined by the scheme arising from negotiations with, amongst others IPA groupings, hospital groups etc.

In addition to the price setting referred to above, the medical schemes prescribe treatment protocols and formularies which must be adhered to by DSPs. These treatment protocols and formularies do not necessarily adhere to best clinical practice and may be regarded as interference in the clinical management of patients by the medical scheme.

3.4 Preferred Provider “Network” Contracts

Direct Payment

In terms of section 59 of the Medical Schemes Act, schemes are permitted to pay either the provider or the medical scheme member when presented with an account for medical services. Where the schemes pay the member directly, doctors face significant
challenges in recouping those monies from the member. Thus, if a doctor wishes to stay in business, he/she has no alternative but to do whatever the medical scheme requires in order to receive direct payment. This almost invariably means that a contract as a "preferred provider" must be entered into.

The above statement is further supported by medical schemes threatening to stop "direct payment" should a doctor be suspected of irregular billing. This threat is often sufficient for doctors to enter into "settlement agreements" with schemes to resolve billing issues.

Treatment Protocols and Formularies
These contracts usually require doctors to strictly adhere to treatment protocols and formularies. Our opinion this that the majority of these formularies and protocols are not necessarily based on best international practice and a largely focussed on cost saving.

It is conceded that the Medical Schemes Act does permit, and even encourage schemes to make use of protocols and formularies. However, we submit that the intention of the legislature in including this provision was not only for the purpose of cost saving.

Contracts negotiated by Third Party groups
Further, many such contracts are negotiated and agreed upon by Independent Practitioner Associations and preferential rates are paid to members of these IPA's whereas non-members qualify for lower reimbursement levels. In order to stay operational and solvent, the doctor will be required to see far more patients in a day than is optimal, which, in turn would lead to a drop in the level of care that the patient receives. We discuss the negotiation of these contracts in greater detail below.

Practice Profiling
Many contracts impose the conducting of "practice profiling" on the doctors. In terms of this process, the doctor's performance is evaluated on financial criteria (how much money is saved) and not on clinical outcomes. Those who save money are rewarded with preferential reimbursement rates. This practice profiling is the most overt evidence of the financial focus of these contracts and that doctors, above all else must ensure the lowest cost exposure to the medical scheme.
### 3.5 IPA’s and Management Companies

Despite the fact that SAMA may not and does not determine a tariff guideline on behalf of its members, other physician groupings such as the Independent Practitioner Organisations, Management Companies and Specialist Societies continue to do so. They disguise their actions by claiming to be price takers, and that they do not actually negotiate tariffs with medical schemes, despite evidence to the contrary. There are management companies that are not owned by doctors, but are independent entities that guide the doctors as to what fee to charge. These fees are negotiated with medical schemes and administrators.

The Designated Service Provider (DSP) and Preferred Provider (PP) contracts are negotiated by Independent Practitioner Associations (IPAs) that in turn receive a fee for every doctor who signs up. As a result preferential rates are paid to members of these IPAs. The scheme’s patients are then forced to go to these network doctors, thereby removing their right to choose a doctor, irrespective of the skill or expertise of the network doctor.

A doctor has a relationship and responsibility towards their patients irrespective of whether or not such patients have health insurance. Restrictive networks however are changing this benevolent paradigm by forcing patients against their will to see network aligned doctors resulting in the following negative consequences:

- A patient’s right to choose the best doctor has been removed, or at the very least, interfered with.
- Access to care has been compromised because many times medical schemes contract with restrictive networks that do not have any clinics or doctors in or close to the poorer communities, forcing these financially challenged patients who can least afford it, to travel vast distances at huge cost to access care that was recently provided by their local doctor, but who is now excluded from the restricted network.
- Despite the fact that many excluded doctors are willing to sign contracts for the sake of continuing to care for their existing patients, restricted network contracts refuses them this right.
- Newly qualified doctors are not even considered for membership of the restricted networks.
The end result is the abrupt severing of numerous long standing doctor patient relationships, patients are forced to consult a new doctor from the restricted network list because these restricted networks use their market dominance to exclude non aligned practitioners which has a negative impact on consumers.

Non IPA members furthermore receive lower reimbursement rates from the scheme, even if they sign exactly the same contracts. Doctors who do not sign the contracts at all, receive an even lower fee, which in effect becomes an inducement for doctors to join the IPAs and sign the contracts. The result is that the IPA leadership impose central control over primary healthcare provision by facilitating these contracts under the guise of peer management in order to advance their own vested interests and then use their market dominance to force non-IPA doctors to join their IPA.

These types of arrangements therefore have the effect of adding numerous layers of non-healthcare costs and exclude independent doctors without any healthcare benefit to the patient.

3.6 Hospital Groups and Medical Scheme Administrators
There are three hospital groups which dominate the private healthcare market, namely Netcare, Mediclinic and Life. Similarly there are a small number of large medical scheme administrators, for example Discovery, who administer a vast number of medical schemes.

It is commonplace for these strong medical scheme administrators to enter into negotiations with the hospital groups in respect of selecting preferential products (consumables, pharmaceuticals) that are to be used in the private hospitals and that will be funded by the medical schemes administered by these administrators.

The result and outcome of these negotiations is that the private hospitals enforce the use of these agreed upon products and medical practitioners who provide health services in these hospitals are obliged to use such products irrespective of their own clinical judgement of what is in the best interests of the patient. These negotiations have a direct impact of the quality of care received by patients and are anathema to best clinical practice, and, we submit, an abuse of market dominance.
held by the hospital groups and medical scheme administrators to the detriment of the public.

3.7 Reference Price List

The National Health Reference Price List was introduced by the Department of Health via regulations to the National Health Act in 2007, and was originally sold to doctors as nothing more than guidelines for private healthcare because it would have been at odds with the Competition Act if it had prescribed the fees. But in practice the guide was and in fact is still being used by medical schemes and the entire health care funding industry as a basis to set limits for the rates that they pay doctors and specialists.

In a press release on the 26 November 2008, the Health Professions Council of South Africa (HPCSA) declared its intention to scrap its ethical tariff used by doctors as a ceiling for patient accounts. The HPCSA stated that the establishment of the new National Health Reference Price List (NHRPL) by the Department of Health eliminated the need for them to publish an "ethical tariff" for doctors. The HPCSA also erroneously stated that the National Department of Health followed an "extensive consultative process" with stakeholders and healthcare practitioners to establish the NHRPL.

The HPCSA then concluded that they will deem practitioners to be overcharging if patients did not consent to a fee charged higher than the NHRPL or the rate payable by the medical scheme; whichever is higher. This was a misinterpretation of section 53 of the Health Professions Act as medical aid schemes are not entitled to determine what a doctor must charge as a fee for their services.

On the 29th July 2010, acting Judge Piet Ebersohn ruled that the health director-general (Health D-G), had failed to comply with the constitution and had acted in a manner that was procedurally unfair. He described the Health D-G's action as "one of disdain and disregard" for the rights of the Hospital Association, which had tried in vain to get the department to consider its proposals for establishing a methodology for determining hospital fees.

At issue was the way the department had determined the fees spelt out in the list, which the applicants argued bore no relation to the cost of running a business. They also challenged the way the department interacted with the parties affected by the tariff
guide. No suitable methodology was established for private hospitals or private emergency services, yet fees were published for these parties, a process the judge described as “irrational and unreasonable”.

Judge Ebersohn ruled that the regulations to the National Health Act that established the reference price list to be invalid and set them aside. He made a sweeping costs order requiring the department to pay not only the applicants’ legal costs but also for the research that formed the basis of their submissions to the department, including two surveys commissioned by the Hospital Association from PricewaterhouseCoopers and Deloitte.

At present there might not be a de facto Reference Price List due to this High Court decision but the 2006 NHRPL is still used as a basis by almost all medical schemes for their tariffs.

We trust that this information will assist the Panel in understanding the actual nature of cost drivers within the private healthcare industry.
PART 3
MARKET POWER AND DISTORTIONS IN RELATION TO HEALTHCARE PRACTITIONERS

1. The Absence of Market Power of Healthcare Practitioners

Despite perceptions that medical practitioners are in a strong, or even dominant position in the private healthcare market given the fact that the market is significantly reliant on their skills, expertise and services rendered, the converse is actually the case.

Medical doctors in the private sector are almost entirely reliant on the medical funding industry to remain “in business”. It is, in fact, the medical scheme industry which occupies the dominant market position.

As we have referred to above, SAMA is precluded, in terms of competition law and the 2003 consent order from any form of negotiation on behalf of its members with medical schemes in respect of reimbursement for services rendered by its members to members of medical schemes. While we have made mention of certain groups (Independent Practitioner Associations) that openly negotiate preferential reimbursement for their members, SAMA consistently adheres to its undertakings and does not negotiate fees with medical Schemes.

In order to secure “direct payment” of fees, doctors are coerced into entering into “Preferred Provider” contracts with medical schemes. These contracts are not negotiated between the individual doctors and the medical scheme, but rather offered to the doctor on a “take it or leave it basis”. As referred to above, such contracts compel doctors to adhere to treatment protocols and medicine formularies (not necessarily in the best clinical interests of the patient). Should a contracted doctor not adhere to the dictates of the medical scheme, that scheme will simply cancel the contract and decline to pay the doctor directly. The doctor must then attempt to recoup monies for services rendered from the patient himself, which gives rise to a significant challenge to doctors who
struggle to obtain payment from patients, even where those patients have been paid by their medical scheme.

The control of the flow of money by medical schemes affords such schemes the complete dominance, not only in respect of determining reimbursement rates, but also in regard of clinical management of patients.

2 The Cost of Practising Medicine

As can be concluded from the information contained in Part 1 of this submission, the individual medical practitioner is largely left to his own devices in respect of determining the appropriate fees to be charged for the services that are rendered.

It is not possible for that practitioner to obtain guidance in that regard from their own professional association, and must, in most instances, accept the fees that medical scheme funders determine and offer. There is naturally an asymmetry of information available. Medical schemes are in possession of significant amounts of data and are able to perform statistical analyses in order to determine what fees they are able to afford to pay. The individual practitioner simply does not have access to this comprehensive data and is clearly in a disadvantaged position. Even if schemes were willing to negotiate with each individual practitioner (which they do not appear to be), the scheme would have the advantage, not only as they control the funds, but also because they possess all the information.

As part of the now defunct NHRPL process, Practice Cost Studies were requested by the Department of Health to be submitted in order for that Department to set an appropriate NHRPL tariff in 2008. The Practice Cost Studies were completed, at great expense, and submitted to the Department, who promptly rejected them. The point which we wish to make here is that the time and expense in compiling and auditing such studies is prohibitive and far beyond the reach of individual medical practitioners. While the studies provide accurate costing data, it is simply not feasible for individual practitioners to conduct them on an annual basis.
3 Coding and Tariff setting
As can be seen from the content of this submission, the existence of coding systems, whether diagnostic, procedural or other is absolutely critical to the healthcare industry. As stated previously, it is the “language” of the industry. This “language” remains distinct from the tariffs that are set for each procedure, service or product described by their particular code.

In short the code is descriptive, not prescriptive and therefore whichever coding system or structure is applicable to the private healthcare industry, there would be no causal nexus between that coding system or structure and the setting of fees or tariffs.

4 Concluding Comments
We would like to thank the Panel for the opportunity to make this submission on a critical matter affecting our members as well as the general public.

SAMA remains committed to constructively participate in this Market Inquiry and remains available to provide any assistance within its powers to assist the Panel.