EXECUTIVE SUMMARY

of

THE SOUTH AFRICAN MEDICAL ASSOCIATION’S

Submission to the

Competition Commission Market Inquiry into

Private Healthcare
The Functions and Role of The South African Medical Association

1.1 Role in the Healthcare Sector
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.

1.2 SAMA’s Relationship with its members
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.

PART 1: The Participation and Contribution Of Sama To The Private Healthcare Industry

1. The Private Healthcare System
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.

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.

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.
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. 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").

2.2 The Health Professions Act, 56 of 1974
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.

Section 53 of the Health Professions Act empowers relevant professional boards to determine the reasonableness of the fees of a medical practitioner. The HPCSA has no regulatory authority over medical schemes.

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 MSA makes provision for Managed Care Organisations and to the provision of Prescribed Minimum Benefits (regulation 8 to the MSA).

3. Procedural Coding

3.1 The SAMA Doctors’ Billing Manual
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. 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. 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.

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. It contains the only broad procedural coding system in use throughout the private healthcare industry.

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 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.

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.

3.3 NAPPI codes
In our full submission we include this coding system as illustration of the inherent need and use of coding in the healthcare industry.

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 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.

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.

3.5 Additions of or modifications to codes in the DBM
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. 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.

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. We 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, 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 (īRAMSī), 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) īthus 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 (īBHFī).

These tariffs were determined as a result of a collective bargaining process between the BHF, Hospital Association of South Africa ("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.
The Competition Commission (Competition 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. 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.

The CMS intervened and published what was called a National Health Reference Price List (NHRPL) for 2004. 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.

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. As a result of the decision in The Hospital Association of South Africa Limited v the Minister of Health and Others (2011 (1) All SA 47 (GNP)), 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.

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. During 2008, the HPCSA withdrew this tariff list.
PART 2: The Economic Factors Contributing To Increased Cost of Private Healthcare

1. Healthcare Economics

When considering healthcare economics, one must combine healthcare supply and demand theories with risk, moral hazard and asymmetrical information. 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

We demonstrate the progress of medical scheme gross contribution income (GCI) inflation from 1981 to 2013 in comparison with the corresponding CPI inflation and show that such contributions are 405% higher than the CPI adjustment. This inflation can be directly attributed to the introduction of managed care and administration costs. We provide evidence that the payment of non-healthcare costs has far exceeded the fees paid to medical practitioners.

Brokers

We show that the exactly the same ratio of the population who had health insurance in 1998 to present date and which proves that despite consuming R10.2 billion of consumers medical scheme contributions, brokers contributed no new members.

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. We have included a comprehensive analysis of these costs contained in our full submission.

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. Hospitals have become the single largest consumer of medical scheme benefits and by far the largest driver of healthcare costs.

Specialists

Specialists have only gained 10% market share from 18.3% to 20.3% from 1997 to 2013.

General Practitioners

GPs have lost a significant 38% market share from 9.2% to 5.6%.
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 R12.1 Billion on not providing healthcare to their members.

Our analysis shows 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. 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.

3.2 Administrators
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.

3.3 Designated Service Providers and Prescribed Minimum Benefits
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. Designated Service Provider (DSP) are appointed by the schemes 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.

3.4 Preferred Provider “Network" Contracts

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. These contracts usually require doctors to strictly adhere to treatment protocols and formularies.

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. Most contracts impose the conducting of "practice profiling" on the doctors. In terms of this process, the doctors’ performance is evaluated on financial criteria and not on clinical outcomes.

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. The Designated Service Provider (DSP) and Preferred Provider (PP) contracts are negotiated by Independent Practitioner Associations (IPAs). As a result preferential rates are paid to members of these IPAs. The schemes' 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.

3.6 Hospital Groups and Medical Scheme Administrators

It is commonplace for the larger 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. 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. 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 paid to providers.

PART 3: Market Power /Distortions In Relation To Healthcare Practitioners

1 The Absence of Market Power of Healthcare Practitioners

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. 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

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. The time and expense in procuring practice cost studies is prohibitive and far beyond the reach of individual medical practitioners.

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.