



THE SOUTH AFRICAN MEDICAL ASSOCIATION
SUBMISSION TO:

The Competition Commission of South Africa
Health Market Inquiry

In respect of

The HMI Provisional Report (5 July 2018)

1 October 2018

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TABLE OF ABBREVIATIONS USED

Abbreviation	Full Term
AGM	Annual General Meeting
ASSA	The Association of Surgeons of South Africa
BHF	Board of Healthcare Funders
CABG	Coronary artery bypass graft
CDL	Chronic Disease List
CMS	Council for Medical Schemes
ENTS	The Ear, Nose and Throat Society
DHET	Department of Higher Education and Training
DSP	Designated services provider
FCPSA	The Faculty of Consulting Physicians of South Africa
FTE	Full-time student equivalents
HMI	Health Market Inquiry
HMO	Health management organization
HPCSA	Health Professions Council of South Africa
HTA	Health Technology Assessment
ICU	Intensive Care Unit
LoC	Level of care
LoS	Length of stay
MSA	Medical Schemes Act
MSAB	Medical Schemes Amendment Bill
NDoH	National Department of Health
NHI	National Health Insurance
NHIB	National Health Insurance Bill
NHLS	National Health Laboratory Services
OECD	Organisation for Economic Co-operation and Development
OHSC	Office of Health Standards Compliance
OMRO	Outcome Measurement and Reporting Organisation
OSSA	The Ophthalmological Society of South Africa
PCNS	Practice code numbering system
PERSAL	Personnel Salary System
PHC	Primary health care
PMB	Prescribed Minimum Benefit
PsychMG	The Psychiatric Management Group
PTCA	Percutaneous transluminal coronary angioplasty
RWOPS	Remuneration for work outside of the Public Service
SAMA	South African Medical Association
SSRH	Supply Side Health Regulator
TURP	Transurethral resection of prostate
WMA	World Medical Association

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1. EXECUTIVE SUMMARY

The South African Medical Association (SAMA) is grateful for the opportunity to comment on the Health Market Inquiry (HMI) Provisional Report, and analyses associated with it.

Although comments on all chapters of the Provisional Report are included, SAMA has focussed on chapters relating to practitioners and cost attribution analyses, as well as analyses examining supplier-induced demand (Chapters 6, 7 and 8).

SAMA's views on a number of the recommendations in Chapter 10 are also provided.

SAMA appreciates the opportunities for engagement and representation, as well as the transparency (within reason), maintained by the HMI throughout the Inquiry processes.

A number of the HMI findings and assertions in terms of behaviour and incentives for medical practitioners cast them in a bad light, and are extremely serious in terms of the Health Professions Council of South Africa's (HPCSA) ethical guidelines. SAMA will therefore to pursue these as a matter of urgency.

Regrettably, in this submission we have had to express our concerns regarding the lack of application of clinically specific knowledge to specialist practitioner and services utilisation analyses, as well as, in our opinion, inappropriate classification and imprecise modelling techniques applied to data, which we believe cast doubt on the findings of the HMI.

While we understand that obtaining data was extremely difficult and that analysis was extremely complex, we also found cases where the interpretations reported in the provisional report were actually not the detail reflected in the technical analytical reports.

In view of the objective that all recommendations of the panel have a factual basis, we found it difficult to support some of the recommendations made on the basis of flawed analyses, or misinterpretation of the analyses.

That said, we are supportive of a number of the final recommendations made by the HMI, in particular those relating to the improvement in quality and outcomes measures, in the private sector, and the full enforcement and implementation of regulatory requirements, which have been insufficient over the years.

2. INTRODUCTION

The South African Medical Association (SAMA) is pleased to submit its inputs to the Competition Commission Health Market Inquiry Provisional Report (July 2018).

SAMA has participated in the Health Market Inquiry (HMI) process since its inception in 2014. The Association also gave multiple inputs on various specific issues to assist the Inquiry Panel to better understand the challenges, roles and responsibilities of medical practitioners in South Africa's private sector.

The private healthcare sector is a difficult environment for our membership to operate in, and SAMA is pleased that the Inquiry concluded its investigations sufficiently to produce a provisional report on the issues examined over the past four years.

SAMA is supportive of many of the recommendations by the panel in relation to regulation, and other interventions, and we hope this report will result in necessary changes to legislation and, most importantly, implementation of existing legislation, where this has been poorly done.

We recognize this poor implementation of existing legislation as one of the most important challenges of the private healthcare sector today.

SAMA also identified challenges in the way the data relating to, in particular, medical practitioners, has been analysed and reported, which we have attempted to address. We anticipate the final report will give clarity in terms of some of these technical issues, so that results generated by the report can be judged as accurate, and recommendations based on these considered appropriate.

SAMA requested access to the HMI data room on 31 July, but this was not granted. Instead, we agreed to examine technical reports and previous publications.

We also requested to meet the HMI Panel on 10 July and again on 15 August, to ensure we had a correct understanding of the analyses informing the provisional report. Unfortunately, to date, we have no confirmation of discussions with the panel or the analytical team.

SAMA also requested an extension of the two-month submission deadline after publication of the report, which was granted. For this we are grateful.

In the interim, we submitted the full report of the SAMA Medical Practitioner Practice Cost Study which was the subject of interactions between SAMA and the HMI during February and March. This was done on 25 August 2018. We will not address the detail of this report in this submission.

Our submission deals with our interrogation of specific chapters and analytics, where we have interrogated the methods and data used. We then provide our perspectives on the recommendations made by the panel (with cross-references to analytical chapters where necessary).

As SAMA does not collect claims, cost or utilisation data from our members, we have relied on expert accounts of members of the various doctors' disciplines interrogated in the report, where there are explanations needed for certain data and patterns to be explained.

2.1 Process for membership inputs to the HMI Provisional Report

SAMA engaged with its membership through multiple channels to gather insights into the report, and the modelling applied to the claims analyses.

We ran several workshops in July and August at most of our 20 branches across the country. At these workshops we also discussed the National Health Insurance (NHI) Bill and the Medical Schemes Amendment Bill, which were published for comment at the same time.

We also held a large workshop on 5 August to which all of our branches and sub-committees were invited, and at which a summary of the findings and technical analyses was presented.

In addition, where necessary, affiliated societies were asked for specific inputs to technical questions such as disease burdens and technological advances within their specialties.

These comments were collated, and interrogation of the provisional report and appendices and annexures was completed, by the Knowledge Management and Research Team at SAMA.

3. CHAPTER 1: LEGAL FRAMEWORK

Throughout the HMI process, SAMA was appreciative of the transparency and stakeholder engagement, which has characterised the conduct of the Inquiry as far as possible.

We note, in particular, the fact that the terms of reference require the Panel “to establish a **factual basis** for recommendations that support the achievement of accessible, affordable, high quality and innovative private healthcare sector in South Africa” (our emphasis).

The principles of factual basis and evidence-informed recommendations have guided our comments on the Provisional Report as a whole.

SAMA believes the Inquiry process proceeded fairly, with ample opportunities for submission and presentation, and we also appreciate the opportunity to comment on the findings in the Provisional Report before these become final.

We also recognise the mammoth task presented by the collection and analysis of claims data by the HMI panel.

However, we are concerned about the appointment of Willis Towers Watson, and then NMG, to assist with data analysis. SAMA considers both of these firms to be contractors of, and affiliates to, medical schemes, and we are perturbed that more emphasis was not placed on the potential conflicts of interest which both of these companies have with regards to medical schemes.

SAMA would appreciate it if the report can provide details on the selection process of WTW and NMG as contractors for data analysis, and the consideration of the vested interests that these two companies have in medical schemes and administrators.

We acknowledge the HMI’s conclusion that all the challenges around data collection underscore the need to develop a comprehensive health information system for reporting of financing, pricing, practices, and several other types of information. Arguably, the Council for Medical Schemes (CMS) already collects such information.

However, this was clearly insufficient to support an Inquiry of this nature. There is a massive and rich amount of data available in the private sector, and the current District Health Information System indicators collect information that, in many cases, is *not* available from claims data in the private sector.

This will, by implication, require setting up a parallel process or defining new indicators for inclusion in the existing system.

SAMA suggests that this data collection be put into context, in line with the National Health Act, and the existing and proposed systems for national data collection.

4. CHAPTER 2: THE REGULATORY FRAMEWORK

SAMA appreciates the overview of the regulatory framework as a starting point for assessing the impacts on competition.

4.1 Inadequacy of the regulatory framework

SAMA agrees that the partial implementation of medical schemes policy into law has been behind a large amount of the difficulties experienced in the private sector. As the HMI notes in later chapters, the regulatory framework has only been 'partially implemented'.

4.2 Lack of regulation and inadequate enforcement

The lack of regulation and inadequate enforcement has been an issue, which SAMA has highlighted in several submissions to the HMI, particularly with respect to the medical schemes environment; SAMA considers the CMS ill-equipped to address the regulatory dealings of medical schemes. SAMA also has to acknowledge that the regulatory environment for doctors has also not been implemented well, and that there remain many shortcomings to be addressed.

4.3 Overregulation of certain aspects

The issues around employment of doctors, as per the references provided by the HMI, have all been submitted by funders and hospital groups, who stand to benefit from a situation where doctors are employed.

We do not believe employment of practitioners by current profit-making entities is desirable, nor necessary, to enhance efficiencies in the system. As in the United States of America, all that is likely to happen, is that corporate profits will be enhanced at the expense of clinician remuneration and quality of care to patients. We discuss these aspects in detail later, in the appropriate section.

Point 5 is interesting given the HMI's recommendations. The multiplicity of regulatory bodies is mentioned, as well as the fact that there are overlapping functions, which make the implementation of the regulatory framework inefficient.

Yet, the recommendations ultimately suggest the development of two new regulators for the private sector: the Supply Side Health Regulator (SSRH), and the Outcome Measurement and Reporting Organisation (OMRO).

While SAMA is actually in support of the improvement of regulation of both of these aspects of the private health sector, we are dubious of the improvements these structures will bring given the failures of the existing regulatory authorities.

SAMA has submitted to the HMI, and remains concerned about, the provisions dealing with the certificate of need in the National Health Act, and fees payable.

We have expressed our opinion that objectives relating to distribution of services could be far better served through incentives provided to facilities and medical practitioners to operate in underserved areas. We believe this is better than denying, or placing moratoriums on, the issuing of licenses to practice in better served areas. SAMA strongly believes the certificate of need provisions will be self-defeating.

In relation to fees and tariffs payable, SAMA agrees that a transparent process for bargaining and negotiating may better serve the country, but we are concerned about the concentration in the funder environment, and the powers exerted by these large players, versus the clinician fraternity which is highly fragmented, and where practice costs may vary considerably.

5. CHAPTER 3: HEALTH SECTOR OVERVIEW

This chapter provides an overview of the private healthcare system and sets the scene for the complexity of the environment in which our membership practising in the private sector operates.

We recognise the skewed distribution of practitioners between public and private sector, but ask that the HMI recognizes that, overall, South Africa is still relatively deprived of healthcare personnel to meet the needs of the country.

The fact that practitioners may work in the public and private sectors - with the Remuneration for Work outside of the Public Service (RWOPS) principle - is important.

While this has been open to abuse in the past, we have observed a much stronger management of most of these instances in recent years, such that we now have practitioners serving both public and private sector alike.

5.1 The history of tariff determination in the private healthcare sector

SAMA believes the current tariff situation to be untenable for practitioners, funders and patients in the private sector.

We appreciate and agree with the detailed history provided in the HMI report on the challenges and changes, which have characterised the tariff determination mechanisms in the country over time.

5.2 Ownership and control in the private health sector

SAMA considers this investigation and analysis by the HMI to be a key aspect of examining perverse incentives and relationships, which potentially could be distorting the market.

The following sentences are extremely important:

“74. This shows that there is a significant commercial relationship between the largest and/or the most influential owners of Discovery Limited, MMI and Mediclinic. The group also has organized relationships with broker markets.

76. Afrocentric's business includes healthcare administration, managed care services, pharmaceutical manufacturing, wholesaling and dispensing, short- and long-term insurance, brokering and HIV and AIDS disease management (managed Care)."

The degree of vertical and horizontal integration in these schemes should have been cause for extreme alarm, it certainly is for SAMA. The potential for common shareholdings and cross-directorships to distort or prevent rigorous competition is very real.

SAMA believes that a recommendation for further investigation of this situation by competition authorities should have been put forward by the HMI.

5.3 Broad trends in the private healthcare sector

SAMA is in agreement with most of the observations in this section, and is not fundamentally opposed to CPI as a comparator for healthcare costs. Essentially, consumers have experienced that their medical scheme premiums and medical costs account for an increasing proportion of their household spend (which would be influenced by CPI). This is meaningful for members of medical schemes and those using private healthcare services.

We recommend the HMI takes a closer look at the non-healthcare costs represented by Figure 3.10 on page 59. The "significant decline" in non-healthcare costs is not a real one.

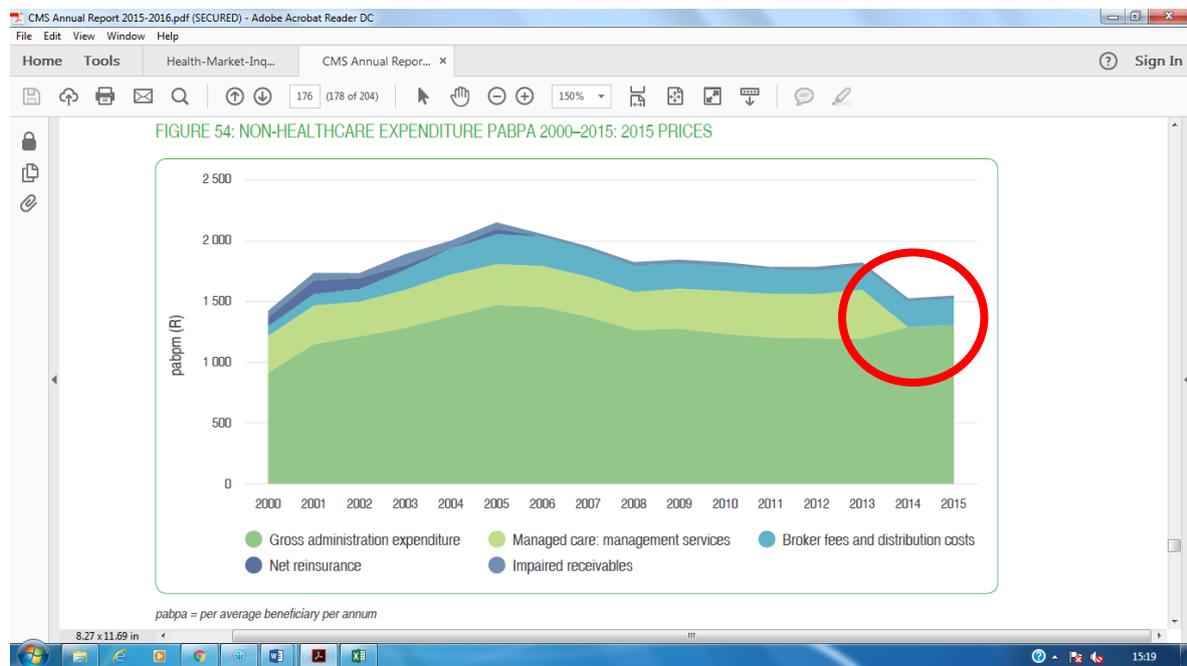
The CMS Circular 56 of 2015: "Accounting for accredited managed care services based on comments received from the industry"¹, effectively removed managed care services from the collective non-healthcare services reporting requirements from 2014. Hence the dip in non-healthcare costs which is presented in the graphs. Instead, managed care agreements are now recorded as healthcare costs.

The change was noticeable in the 2015/16 Annual CMS report. Figure 54 from this report is reproduced below.

¹ Council for Medical Schemes. 2015. Circular 56 of 2015: Accounting for accredited managed care services based on comments received from the industry. Available at: <http://www.medicalschemes.com/files/Circulars/Circular56Of2015.pdf>. Accessed 24/09/2018

The CMS reported that Circular 56 resulted in the 2014 non-healthcare expenditure decreasing by 21.5%.

This was because of a substantive change in accounting allocation, which SAMA deems inappropriate.



This is a significant amount of money, and involved in excess of R3bn simply being removed from the non-healthcare expenditure framework.

SAMA questions the CMS's rationale in affecting this change in accounting for managed care. We believe this is something, which should have been interrogated by the HMI as it represents the impact of scheme pressure on the regulator to serve their purposes rather than regulate appropriately.

It is now difficult to examine the changes in managed care costs that the schemes incur, which we believe is what the desired outcome of this initiative was. In effect, it has artificially lowered and obscured non-healthcare costs incurred by medical schemes.

SAMA would like the HMI to interrogate what this change in accounting may have done to perceived healthcare expenditure. Although we note that it might not have had an influence during the period from 2010 to 2014, it should be examined in the practitioner and admissions analyses.

6. CHAPTER 4: COMPETITIVE ASSESSMENT FRAMEWORK

SAMA is comfortable with the Competitive Assessment Framework applied by the HMI, as well as the theories of harm, which the HMI considered for its analysis.

We consider that not all the potential market power and distortions mentioned for practitioners in paragraphs 11, 12 and 13 were actually investigated in the HMI, but note the significant attempts to do so in later chapters.

7. CHAPTER 5: FUNDERS

SAMA is grateful for the recognition in paragraph 27 of this chapter that, although medical schemes maintain they are not motivated by profit, there is strong alignment between medical schemes and their profit-making administrators.

We regard this strong alignment to be inappropriate and damaging for competition and medical scheme premium levels.

SAMA is in agreement with the HMI's concentration analysis and findings in paragraph 33 that the funder market for medical schemes is extremely concentrated and dominated by only a few large entities.

7.1 Barriers to entry for new medical schemes

SAMA is in agreement with many of the findings of the HMI in paragraphs 34 to 56, and the conclusion that barriers to entry within the schemes environment have been high for new entrants.

This is partially the result of the existing regulatory framework, which, SAMA believes, has served to protect medical scheme membership, more than before the introduction of these regulations.

However, SAMA agrees that challenges such as risk and solvency requirements may have stunted the ability of new schemes to enter the market.

7.2 Partial regulatory framework for medical schemes

The risk adjustment mechanism, which is highlighted as one of the solutions to this problem in this chapter, and the Recommendations Chapter, was mooted for legislation from the beginning of the implementation of Prescribed Minimum Benefits (PMB) Legislation.

SAMA considers this risk adjustment necessary for the system to effectively be able to implement a standard basket of benefits across all schemes.

Figure 5.4 in the Provisional Report is extremely significant with regard to the inconsistency with which PMBs are offered by medical schemes.

Clearly, if the package was indeed a standardised one across all schemes, we would expect the costs per member to at least be within one order of magnitude from each other.

SAMA takes the variation in PMB Costs in Figure 5.4 to indicate variation in risk of different schemes, as well as the fact that schemes are paying differently for PMB entitlements. Our doctor membership experiences this inconsistency and differences between medical schemes' reimbursement of PMBs daily.

We are in agreement that the process of applying for PMB cover is cumbersome and complicated - sometimes, we believe, deliberately so.

SAMA disagrees with the HMI on paragraph 74, where the naming of PMBs and non-PMBs is mentioned, and supposedly reported in Chapter 8 – supplier-induced demand. In the funder chapter, the HMI concludes that there has been in a shift between 2010 and 2014 in the diagnosis of PMB versus non-PMB conditions.

This shift could purely be due to awareness of the PMB entitlement, and as a result of Code of Conduct published by CMS in 2010.

SAMA failed to see evidence of this in any of the HMI analyses on practitioners. What is evident in Chapter 8 (paragraph 60), however, is that *“Non-PMB conditions appear significantly more influenceable than PMB by clinicians, suggesting that PMB regulations are not the main driving factor of supplier induced demand.”* Chapter 8 reports that PMBs have not been cost drivers.

SAMA is thus not sure what the HMI is trying to conclude, or where the factual basis for the variation in PMB diagnoses is derived from; the data seems to show something other than what Chapter 6 claims about gaming codes for PMBs.

7.3.1 Risk Pooling and Risk Equalisation

SAMA agrees with many of the assertions made by the HMI in this section. We have submitted to the HMI process, and participated in a seminar on the healthcare financing regulatory framework and the impact it has on competition in the South African private healthcare sector in early 2018.

In this submission, we highlighted concerns of scheme options, which had been permitted to continue making losses over several years, and *the “reverse income-cross-subsidization”* from mid-level schemes to top benefit options.

While there is some cross-subsidisation from mid-level schemes to lower level schemes (also making losses every year), the quantum of subsidy is far greater to top benefit options. This concept will further deepen the inequity gap between South Africans. It is a pity the Health Market Inquiry did not explore equity, equality and fairness, despite it being the Competition Commissioner’s purpose of ensuring equity and efficiency in the South African economy.

On 21 September, the CMS released the scheme consolidation framework, which will start with the consolidation of schemes and maybe later the consolidation of option plans. We believe the HMI should interrogate this consolidation framework in view of market failures associated with concentration.

This has been of great concern to SAMA, as we see these options competing on the basis of excessively rich benefits.

SAMA agrees that the number of benefit options is excessive and the differences between these options difficult for members to distinguish. SAMA therefore supports benefit option consolidation, but we believe that scheme consolidation is premature.

7.3.2 Medical savings accounts

We have noted that schemes continue to fund PMB services from Medical Savings Accounts, despite this being prohibited by the Medical Schemes Act (MSA).

It is true that Savings Accounts may limit the extent of cross-subsidy, however, the effect is minimal.

7.3.3 Mandatory Membership as the solution to anti-selection

SAMA agrees that the perceived “twin peaks” phenomenon within medical schemes membership (Figure 5.6 of HMI Provisional Report) is driven by multiple factors, including a black population, which is battling to catch up in terms of income and ability to join medical schemes.

In our recent submission in response to the Medical Schemes Amendment Bill, we highlighted our concerns in relation to late-joiner penalties and how these negatively impact previously disadvantaged populations.

SAMA also expressed our concerns around the negative impacts and poor implementation of underwriting by the medical schemes. We recently saw examples where medical schemes underwrite based on any declaration of any previous condition, whether this is clinically appropriate or not.

For example, a member applying disclosed a history of sciatica five years ago. MRI results were submitted with minimal evidence of degenerative spinal disease. The member was nevertheless underwritten for all possible spinal conditions such as TB, fracture, congenital diseases of spine, degenerative diseases of the spine, and any other spinal condition and so forth.

We are thus **not** in agreement with point 160, in which the HMI recommends that the level of underwriting may need to be reconsidered and increased.

We do not believe underwriting at scheme level is applied appropriately or fairly at the moment and we therefore cannot recommend “increasing” underwriting levels at this stage.

7.3.4 Conclusions on Partial Regulatory Framework

SAMA is in full agreement with the HMI that the regulatory framework of the private healthcare sector suffers from lack of attention, and that urgent action is required.

SAMA is in favour of the introduction of a risk equalisation supported core package of services.

SAMA also agrees with paragraph 169, that there is an urgent need to address the PMB environment – particularly given that this is set to change drastically in the current PMB Review.

During this process (running from the end of 2016 to date), multiple stakeholders identified the current lack of adherence to PMBs, and current non-compliance by

medical schemes with the Regulations, as implementation risks for any form of basic mandatory benefit package.

7.4 Governance of medical schemes

7.4.1 Relevant legal framework

SAMA notes that the legal framework examined by the HMI is contained in the current Medical Schemes Act (MSA), not that which is contained in the Medical Schemes Amendment Bill (MSAB, June 2018). While sections 29 and 37(1) have remained unchanged, section 57 has been entirely repealed in the Bill, and has largely been replaced by more detailed roles and responsibilities in Section 56A.

However, fundamentally, the fiduciary responsibilities of trustees have been maintained and governance requirements strengthened.

SAMA is in favour of strengthened trustee elections, improvement of communication of scheme AGMs (Annual General meetings), as well as improvements to the requirements for skills, competence and training of trustees.

SAMA would also be in favour of a remuneration framework for principal officers and trustees, as the HMI correctly notes that current remuneration packages do little to incentivise principal officers and trustees to manage costs and improve scheme growth.

7.4.2 Medical scheme role in relation to administrators and other third parties

The relationships between medical schemes and their third-party administrators have been of great concern to SAMA. We note that some improvements in governance with regard to these relationships have already been put forward in the Medical Schemes Amendment Bill.

7.4.3 The role of brokers

SAMA is pleased that the HMI gave substantial attention to the role of brokers. Our membership indicated, in discussions regarding the Medical Schemes Amendment Bill, that medical scheme members seldom seem to receive objective and well-

informed advice from brokers, even when they use their services. Brokers frequently seem to add little value to their clients in terms of understanding the difference between scheme options, and the advantages and disadvantages of choosing one scheme or option over another.

We believe there are a number of perverse incentives operating in this market. SAMA is in favour of the conclusions and recommendations of the HMI regarding brokers, and the need to address incentives and transparency of broker remuneration, in paragraphs 289 to 293.

7.4.4 Demarcation regulations

SAMA agrees with the HMI observations. Our view is that the Medical Schemes Act was specifically promulgated to protect members against financial catastrophe.

Gap covers and Primary Health Care (PHC) packages emanated from weaknesses in the system. At the time of the MSA promulgation, the government intended to provide primary healthcare for everyone. Unfortunately, a segment of the population was left with inadequate health cover. This group could typically afford a GP consultation, but not a medical aid, and have barriers to access public sector.

The implementation of a good comprehensive package that includes PHC alongside a tariff negotiation mechanism should eliminate a need for GAP and PHC plans.

7.5 Part 2: Medical Scheme Administrators and Managed Care organisations

7.5.1 Profitability analysis

The interpretation of the profitability analysis was difficult with much of the detail having been cut from the report.

SAMA agrees with most of the HMI's findings in the profitability analysis, as well as concerns raised.

Discovery Health's per patient administration and managed healthcare fees have remained high relative to the industry, in spite of the fact that the size of the

membership should be demonstrating economies of scale for the administrative functions.

It must be recognised, however, that Discovery Health is exceedingly innovative and agile, in relation to many other administrators. While the profitability of Discovery Health can be questioned as being consistent and way above that of other administrators, there is little doubt that Discovery Health is the intellectual and service leader of the market. If innovation is to be encouraged, this surely also should be rewarded.

8. CHAPTER 6: FACILITIES

This section in the report needs to be revised for some editorial errors, referencing errors, and correctness in interpretation.

For example, paragraph 219 refers to figure 6.10 for distribution of public sector beds. Distribution of public sector beds is, instead, highlighted in Figure 6.13.

Similarly, paragraph 222 describes distribution of public sector beds contrary to what is stated in Figure 6.13.

8.1 Development of the private hospital sector

SAMA takes cognisance of the differential growth in the public and private hospital sector.

It is concerning that the number of public sector beds has decreased between 1998 and 2015.

Therefore, to improve efficiencies and access to healthcare, it is imperative that government utilises excess capacity in private sector through strategic purchasing as recommended in the chapter.

SAMA has advocated for the use of under-utilised private sector beds, through universal coverage policies.

8.2 Market definition

SAMA agrees that public sector and private sector hospitals are different and cannot compete at the moment. However, any successful funding model, whether NHI or medical schemes, should create incentives for competition on quality and value.

Public sector as alternatives for private sector

SAMA is concerned that some medical schemes use state facilities as Designated Service Providers (DSPs), despite the Health's Ombudsman negative finding on the state of public hospitals.²

This demonstrates that funders *do not* contract on quality of services but on costs alone. We have also received feedback that in many cases, no contracts are in place with public sector facilities which are supposedly DSPs. Patients are merely forced to use "public sector" facilities – regardless of the spectrum of services available at these facilities.

8.3 Concentration Analysis and Creeping Mergers

SAMA agrees that the market is concentrated at national level, and there may be both competition and dominance at local level.

Of importance are rural towns, which may have only one hospital. Yes, there might be dominance in that area, however the medical scheme population may also be smaller.

We believe hospitals in rural towns serve an important role in access for surrounding areas and may be fundamentally different in their service offerings, processes, and structures from those in metropolitan areas.

SAMA agrees that mergers can result in anti-competitive behaviour and supports the draft Competition Amendment Bill proposal to scrutinise mergers and acquisitions from a concentration perspective.

8.4 Distribution of beds across provinces

SAMA welcomes the more detailed analysis of distribution of beds.

In our previous submission on facilities³ we highlighted that although some provinces increased the number of private sector facilities and beds, this may have been done to address undersupply.

² OHSC: Annual Inspection Report: 2016-2017

³ SAMA: HMI submission of Facilities. 26 February 2018

This is confirmed by the HMI findings in Figure 6.11, where the undersupply in private sector beds is acknowledged.

We can confirm that this results in unfunded use of public sector facilities, which invalidate the objectives of prescribed minimum benefits⁴ to improve efficiency in resource allocation between public and private sectors.

8.4 Relationship between facilities and practitioners

SAMA acknowledges the identified perverse incentives between practitioners and health facilities, and the associated market failures. We are particularly concerned with regards to contracting arrangements that marginalise previously disadvantaged doctors.

SAMA is an affiliate to the World Medical Association (WMA), which advocates autonomy and independence of medical doctors - an essential principle in medicine. The WMA statement on professional autonomy and clinical independence asserts that:

“The central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals”.

Furthermore, the Health Professions Council of South Africa’s (HPCSA) guideline on perverse incentives, contained in booklet 11 states that:

“Healthcare practitioners shall not engage in or advocate the preferential use of any health establishment ... if any financial gain or other valuable consideration is derived from such preferential usage”

Although the HMI did not consider the perverse incentives to be improper, and maybe pro-competitive, SAMA believes the HPCSA needs to examine these perverse relationships, as they are not aligned with patients’ interests.

⁴ Medical Schemes Act 131 of 1998 (Regulations) Annexure A.

If the allegations of the report, that the benefits offered to doctors, by facilities, have an element of incentives in them, these will require careful scrutiny to determine if indeed they contravene ethical codes of conduct.

9. CHAPTER 7: PRACTITIONERS

SAMA interrogated the chapter on practitioners in great detail as this is our primary area of knowledge, understanding, and expertise. We were, however, disappointed that Discovery Health analyses and data was quoted throughout this chapter as if it is an authority. We would like to remind the HMI that Discovery Health is an administrator and not, in any way, an authority on clinicians.

9.1 Supply of doctors in private health market

SAMA was pleased to see the recognition on page 302 of the HMI report that the number of medical practitioners and specialist medical practitioners per 100 000 of the population in South Africa is *low* overall.

There is a critical shortage of particularly specialists, even in the private sector in South Africa. We are also pleased to see that notice is taken of medical practitioner availability per population in the private sector in relation to the total in systems in other countries.

As is demonstrated by HMI Table 7.1, SAMA would agree that there is a greater concentration of medical practitioners in Gauteng, the Western Cape and KwaZulu-Natal, than in other parts of the country. The same can probably be said for any service-based professionals such as lawyers, pharmacists, accountants, allied health professionals, plumbers, electricians, etc.

A similar distribution also occurs in the public sector, with public sector doctors being more highly concentrated in Gauteng, the Western Cape and KwaZulu-Natal. Of the 4737 specialists in the public sector, 85 percent are based in the above three provinces, understandably so, as these provinces have a higher concentration of regional, tertiary, and quaternary hospitals⁵.

We note that in point 32 the HMI recognises that, *“It is reasonable to assume that some concentration of specialists should occur in urban areas and that these*

⁵ Health Systems Trust. South African National Health Review, Chapter 21: Health and Related Indicators. Page 304-305. Available at <http://www.hst.org.za/publications/South%20African%20Health%20Reviews/HST%20SAHR%202017%20Web%20Version.pdf>. Accessed 01/09/2018.

specialists may be seeing patients referred to them from further afield than their immediate area.”

Given this recognition, it is not clear why this was not considered in the logistic regression model in Chapter 8, which simply viewed municipalities as the appropriate geographic areas for specialists and patients. We address this issue in the comments sector of Chapter 8.

We also note the conclusion in point 33 of Chapter 7 that “some districts have no specialists at all”.

Indeed, in a country where supply of specialists is limited, it might make sense to deliberately centralise specialist services, as has been the debate in several other countries⁶. This balance between centralisation and access must be considered in the context of the availability of both private and public hospitalisation facilities in these districts, from where specialist doctors can work, particularly in the case of surgical specialities.

It is telling that a look at the District Health Information System reveals there are also no regional or central public sector hospitals in any of the districts with no specialists. As the number of regional and central hospitals increases, so does the number of specialists (Table 1).

We argue that the centralisation of specialists is not unusual globally (and is actually a policy objective in several countries), and that the lack of facilities and incentives is responsible for the patterns observed.

⁶ The Kings Fund. (2014) The reconfiguration of clinical services: What is the evidence? Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf. Accessed 05/09/2018.

Table 1: Public regional and central hospitals in districts with lowest five-year averages of specialist per 1000 insured population⁷

District	Regional hospitals	Central hospitals
Central Karoo	0	0
Greater Sekhukhune	2	0
John Taolo Gaetsewe	0	0
Alfred Nzo	0	0
UmKhanyakude	0	0
Umzinyathi	0	0
Xhariep	0	0
Zululand	0	0
Amathole	0	0
Joe Gqabi	0	0
Dr Ruth Mompati	1	0
Vhembe	1	0
Pixley ka Seme	0	0
Waterberg	1	0
Chris Hani	1	0
Harry Gwala (Sisonke)	0	0
Gert Sibande	1	0
Fezile Dabi	1	0
Mopani	1	0
Namakwa	0	0
Sara Baartman (Cacadu)	0	0
West Coast	0	0
ZF Mgcawu (Siyanda)	1	0
Thabo Mofutsanyane	2	0
Nkangala	0	1
Lejeweleputswa	1	0
OR Tambo	2	1
Utukela	1	0
Ugu	1	0
Ehlanzeni	2	1
West Rand	1	0

SAMA notes the point made in Reference 16 on page 309 regarding the fact the training of healthcare practitioners is highly subsidised and borne mainly by the

⁷ Health Systems Trust, Health Indicators. (2016). Available at: <http://www.hst.org.za/healthindicators>. Accessed 05/09/2018.

national fiscus, and that this represents a cross-subsidy of the private sector by the public sector.

SAMA is disappointed to see such an archaic viewpoint still being argued. *All* university students in South Africa are subsidised by public sector funds, on the basis that university education generates new knowledge, and produces research which leads to new commercial, technological, social, political, and other innovations beneficial for national development. The primary sources of funding are the Department of Higher Education and Training (DHET) block grant based on the system of full-time student equivalents (FTEs), and student fees.⁸

For most universities, state support, on average, accounts for more than two thirds of their unrestricted revenue. In addition, the majority of taxes collected for the national fiscus are from personal income tax, and therefore originate from privately employed individuals. The production of medical graduates is a public service to produce medical professional for the good of the whole country.

We note point 43 and Table 7.2 of the HMI Report which highlight the steady entry of practitioners into the private sector for the period for which data was available.

It is positive for competition that barriers to entry do not appear to be insurmountable.

SAMA attributes at least some of the growth in the number of private practitioners to push factors from the public sector, and the progressive decrease of posts in the public sector in recent years (Figure 1), as presented on the basis of PERSAL (Personnel Salary System) and government expenditure. Up until 2013, posts were on the increase, but for the period, which was examined, posts in the public sector decreased annually in real terms. This has been as a result of budget cuts and the freezing of posts by provincial departments.⁹

⁸ Universities South Africa (2016). Universities Funding in South Africa: A Fact Sheet. Available at http://www.uct.ac.za/usr/news/downloads/2016/UniversitiesFundingSouthAfrica_FactSheet.pdf. Accessed 01/09/2018.

⁹ National Department of Health Parliamentary Report to the Standing Committee on Appropriation. April 2017.

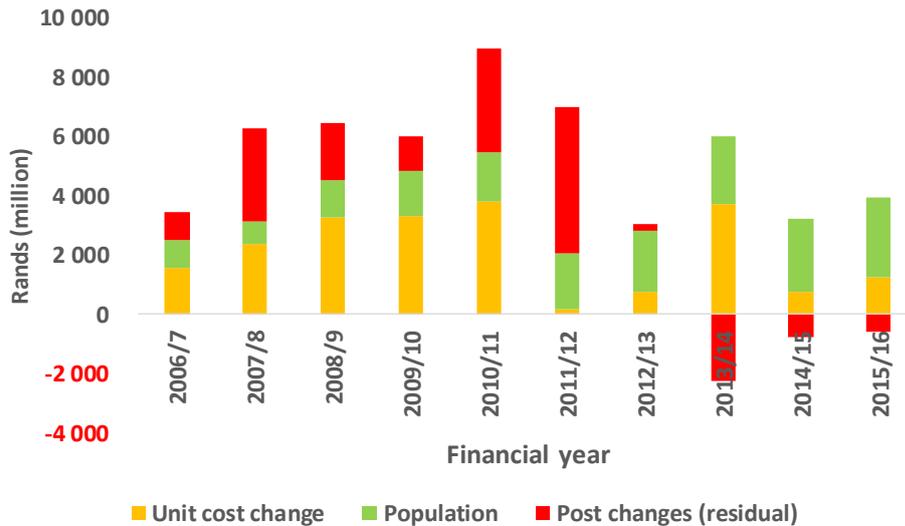


Figure 1: Real changes in **public health sector remuneration** broken down by **cost driver** (from 2005/6 to 2015/16) (2015/16 prices) Presentation by Professor Alex van den Heever at the SAMA Annual Conference, August 2018

Other push factors from the public sector include poor working conditions, and the perception of a better environment in the private sector.

9.2 Barriers to entry in the practitioner environment

On the whole, SAMA agrees with the HMI's assessment of barriers to entry for medical practitioners.

We are pleased that the HMI notes that regulatory control over training standards, curricula and registration is necessary, and on balance positive and beneficial to consumers and society.

9.3 Medical Practitioners' Engagement in the Market: Evidence from Billing Practices

9.3.1 Analysis of claims data

SAMA notes the attention to factors, which the HMI considered to logically make a difference in healthcare claims. But, we note, the analysis has not specifically considered issues such as the impact of enforcement of Prescribed Minimum Benefit entitlements and Regulation 8 of the Medical Schemes Act, developments in health technology, potential costs of earlier detection of illness, and the ability to treat patients who would otherwise not have been treated with older technologies.

9.3.2 Improvement of PMB entitlements and enforcement of Regulation 8 of MSA

The period of HMI analysis coincides with a period where CMS was trying to enforce the MSA Regulation 8 on payment in full. This was following an unsuccessful bid by the Board of Healthcare Funders to request the court to issue a declaratory order on the interpretation of the words "pay in full" in Regulation 8(1) of the General Regulations made pursuant to the Medical Schemes Act, 131 of 1998.

In 2010, the CMS published the PMB Code of Conduct¹⁰, compiled by a task team consisting of the Council for Medical Schemes, the National Department of Health (NDoH), medical schemes, and administrators. The immediate objective was to develop a code of conduct whereby PMBs could be offered to members of medical schemes in compliance with current legislation.

This was soon followed by the inception of the PMB Definition project.¹¹ The objective of the PMB definition project was to define prescribed minimum benefit entitlements and liabilities faced by the schemes.

At least some of the increase in costs can therefore be attributed to improved coverage and enforcement of PMBs. This is a positive aspect in terms of the legislative entitlements of beneficiaries.

Some of the earlier conditions reviewed in the PMB Definition project include transplants, cancers, and Ischaemic Heart diseases, with schemes now being forced to adequately fund these conditions.

These conditions are generally not cheap to treat. Most importantly, the enforcement of Regulation 8 expanded cover for chronic conditions reimbursed out-of-hospital, including access to pathology, rehabilitation services, and radiology.

¹⁰ Council for Medical Schemes. 2010. Code of Conduct in Respect of PMB Benefits. Available at: www.medicalschemes.com/files/.../CodeOfConduct_20100803.pdf. Accessed 04/09/2018.

¹¹ Council for Medical Schemes. 2010. Invitation to participate in the Prescribed Minimum Benefit Definition project. Available at: www.medicalschemes.com/files/Circulars/Circular45Of2010_20100914.pdf. Accessed 04/09/2018

9.3.3 Technological developments

An example of this is brachytherapy for prostate cancer, which was introduced into South Africa from 2004. Initially, the costs were prohibitive as there was only one seed supplier in the country. However, when competitors entered the market and prices dropped, brachytherapy became a viable treatment option. This technology, which has enabled a far less invasive intervention for localised prostate cancer, caused brachytherapy effectively to become a Prescribed Minimum Benefit level of care in 2012, when it was introduced into the public sector. Brachytherapy has changed the benefit-risk balance of treatment in early prostate cancer. In addition, it has emerged in the last decade that black men in South Africa diagnosed with prostate cancer are more likely to suffer aggressive forms of malignancies¹². A traditional watch-and-wait strategy is therefore clinically not appropriate in our setting.

There have also been major technological advancements in areas such as ophthalmology, orthopaedic surgery, and surgery in general which have made procedures in patients who may not have qualified before possible, and the ability to address conditions earlier, and not having to wait until a patient is fully debilitated by, for example, cataracts or joint defects, before receiving clinical care to correct these.

Technological developments are not negative developments, nor are compromising to patient care.

They deserve to be celebrated in terms of progress and improvement of quality of care and access to treatment.

However, we have not seen anywhere where the claims data analysis took the effort to examine the possibility of how these advancements have been positively impacting patient care.

9.3.4 Disease Burden considered for the analysis

SAMA notes the rationale behind the choice to use the narrow disease burden for adjustments to the burden of disease. Claims data from medical schemes in the

¹² Tindall EA, Monare LR, Petersen DC et al (2014). Clinical Presentation of Prostate Cancer in Black South Africans. *Prostate*. 2014 Jun; 74(8): 880–891.

private sector uses the Prescribed Minimum Benefit Chronic Disease List (PMB CDL list) to define chronic conditions.

The PMB CDL list only includes a few conditions, which kill South Africans in large numbers. The HMI can therefore not conclude that there are unexplained admissions after adjusting only for chronic diseases and age.

SAMA believes the increase in admission can be explained by the high prevalence of injuries, acute infections, cerebrovascular accidents, cancer, tuberculosis, and substance abuse, among several other factors.

9.3.4 Out-of-Hospital Claims Analysis

SAMA recognises that the HMI needed to summarise the Focus on Practitioner Report analysis for readability of the final report. However, in our opinion, many of the important observations made in the original technical report have been completely omitted from the HMI Provisional Report, which we believe diverts the focus from where it should be.

The HMI has concluded that there is supplier-induced demand, which would suggest an increased number of encounters and procedures within medical practitioner services in the country. Yet, as demonstrated in HMI report Table 7.5 on page 322, for several of the disciplines, *average annual increases in visits has been negative or marginal* (gynaecologists, paediatricians, orthopaedic surgeons, dermatologists, general surgeons, otorhinolaryngologists).

The really large increases have been in the average cost per visit. SAMA considers this to be more as a result of a failed tariff and billing process, and the result of technological advancement, than supplier-induced demand (which would have increased volumes dramatically).

Thus, we disagree with the summary conclusion in paragraph 108 which makes a blanket statement that rising costs are “partly driven” by increased utilisation; this may be the case for specific reasons in particular disciplines, but this is not the case in the whole clinical spectrum.

Throughout this report the HMI needs to guard against the generalisation of findings in certain groups to the whole practitioner market; each discipline is faced with its own technological advances and changing disease burden that deserve to be carefully considered before broad-stroke conclusions can be made.

SAMA agrees with the analysis presented in HMI Report Table 7.6, and the conclusion, that with improved care coordination, cost savings are possible, but that this cost saving should not be the only goal of care coordination.

We understand that better care coordination will no doubt improve clinical outcomes, although this aspect in the HMI Provisional Report analysis only examined the claims costs.

9.3.5 In-Hospital claims analysis

Once again, the in-hospital claims analysis shows a far greater on average increase in cost per admission than the number of admissions per year, leading us to conclude that it is not volumes driven as a result of supplier-induced demand for admissions.

There is admittedly one discipline where there are higher increases in admission rates in both day hospitalisation and overnight admissions, namely physicians, which may warrant further scrutiny. We acknowledge the HMI's concession that physicians are a complex group and not necessarily homogenous.

Provider fees have increased on average by 9.36%.

SAMA feels this is the result of multiple factors working together, none of which have been taken into account in the adjustments of the data. These include increases in defensive medicine as a result of increased medico-legal cases in certain disciplines, technological advancements in clinical procedures, and benefit structures which drive hospitalisation. The change in cost per admission is considerably more striking than rates of admission for both day admission costs and overnight admissions for most disciplines.

In paragraph 124, the HMI Provisional Report rightly notes the need to understand what motivates increases in admission rates. However, we feel the diagnosis might

be wrong in this case. For most disciplines (not all) the increase in admissions has been far less than the increase in cost per admission. If the factors such as buy downs and increased unnecessary hospitalisations were really driving factors, we would expect to see an increase in shorter term stays, and admissions for less serious conditions, than might not require hospitalisation in normal circumstances.

In the attribution analyses conducted, both day and overnight admissions have been combined so it is difficult to discern more and less complicated admissions.

There are also combinations which SAMA has difficulty making sense of which we might want to examine in a medically necessary environment:

- The inclusion of plastic surgery into the general surgery grouping makes it difficult to distinguish what may have been elective cosmetic surgery admissions from elective, but necessary medical surgery admissions.
- Combining of medical and radiology oncology makes it difficult to establish any patterns attributable to each of these groups.

In terms of explained and unexplained factors, SAMA once again believes the HMI has not done a proper job interrogating how each discipline is impacted by burden of disease changes and technology changes, and what may be influencing the specific discipline in terms of admissions, Length of Stay (LoS), and Level of Care (LoC).

The most significant trends from the tables are:

- Large increases in admission rates (5.13%) for ophthalmology, offset by a reduced length of stay (-3.82%) and level of care (-5.02%);
- A high cost increase (12.04%) for urology associated with a high increase in admission rates (3.79%);
- A similar but even higher cost increase (14.67%) for internal medicine, driven primarily by admission rates (5.87%);
- Reduced cost of medical gastroenterology, with reductions across all three components;
- High cost increases (17.65%) for neurology, with high increases in admission rates (7.97%); and,
- High cost increases (13.49%) for psychiatry, with increases in length of stay (4.14%) and to a lesser extent admission rates.

SAMA has additional observations, which we believe are extremely material to the analysis and conclusions:

Cardiothoracic surgery

Even with a narrow disease burden considered, the majority of cost increases are in line with CPI and explanatory factors.

Issues such as morbid obesity in this population would not have been considered and could certainly have contributed to unexplained costs of admissions¹³. Admission rates are almost completely explained, with unexplained factors seemingly contributing to reduced admissions. Level of Care trends have, in fact, been negative over time.

Similar patterns of attribution are clear for general surgery.

Neurosurgery and obstetrics and gynaecology, and orthopaedics

The highest proportion of unexplained factors occur in the Level of Care. SAMA does not believe this is a coincidence. O&G, neurosurgery, and orthopaedics, are also three of the disciplines worst affected by increasing medical malpractice cases and rising indemnity insurance premiums as a result. We surmise that the increased levels of care could be a defensive mechanism to mitigate against litigation. However, the HMI has not been able to consider this as part of their analysis.

Ophthalmology

The length of stay, and the level of care, have decreased substantially although costs and admissions have increased. This is indicative of higher volume, and lower intensity practices, probably within specialist ophthalmology facilities, where new technology has been adopted.

This includes femtosecond laser technology for cataract surgeries, and advanced lens implants for cataract surgery, corneal cross-linking, kera and ferrara rings, and anterior lamellar keratoplasty for keratoconus.

¹³ Statistics South Africa. 2016. South African Demographics and Health Survey Report: Key Indicators. Available at: www.mrc.ac.za/sites/default/files/files/2017-05-15/SADHS2016.pdf. Accessed 20/09/2018

Prior to the development of modern intraocular lenses and surgical techniques, patients were often told they must wait for surgery until their cataract was "ripe." Cataract extraction in that era was deferred until the vision was poor in both eyes. Surgery involved greater risk to the eye and required several weeks of immobilisation. This is no longer necessary.

Evidence has also developed that treating both eyes simultaneously for cataract (and not waiting for a recovery period of the first eye) has similar outcomes to multiple procedures. A retrospective study comparing immediate (same day) with delayed (within one year) surgery on the second eye found no difference in postoperative best-corrected visual acuity, refractive error, or complication rate¹⁴. If doctors are performing cataract surgery increasingly on both eyes at a time, this would also impact on the cost per procedure, but negate the need for a second procedure several months later. However, these aspects were not addressed in the modelling for ophthalmology. The large proportion of "other" factors contributing to increases is unclear in its role.

Psychiatry

Hospitalisations are due to the largely hospi-centric nature of mental health PMB entitlements. Most of the treatments and benefits for these conditions are hospi-centric, and implementation of community-based mental health has generally been poor in both the public and private sectors. This has been matched by increasing awareness of mental wellbeing and concerted efforts to remove stigma around mental health issues and encouragement of those suffering to seek help.

SAMA would like to see each discipline better interrogated as we do not agree with the HMI's concluding assumption in paragraph 134 that "... unexplained increases point to inappropriate drivers of claims costs", and the following paragraphs which examine incentives influencing practitioner behaviour.

¹⁴ Herrinton LJ, Liu L, Alexeeff S, Carolan J, Shorstein NH. 2017. Immediate Sequential vs. Delayed Sequential Bilateral Cataract Surgery: Retrospective Comparison of Postoperative Visual Outcomes. *Ophthalmology*. 2017;124(8):1126. Epub 2017 Apr 21.

9.4 Medical Practitioner Affiliation Analysis

SAMA is particularly disappointed in how this analysis has been reported versus what the actual analysis in the practitioner technical report showed.

It is clear that practitioner fees cluster around medical scheme rates in most instances. This is an indication that doctors are truly price takers, and medical schemes are determining reimbursement rates across the board with very little variation.

The analysis for specialist affiliation looked at the following affiliations:

- i. The Association of Surgeons of South Africa (ASSA), a grouping of general surgeons;
- ii. The Ear, Nose and Throat Society (ENTS), a grouping of otorhinolaryngologists;
- iii. The Faculty of Consulting Physicians of South Africa (FCPSA), a grouping of specialist physicians, dermatologists, pulmonologists, medical gastroenterologists and rheumatologists i.e. consulting specialist disciplines;
- iv. The Ophthalmological Society of South Africa (OSSA), an association of specialist ophthalmologists;
- v. The Psychiatric Management Group (PsychMG), an association of specialist psychiatrists;
- vi. Surgicom, another grouping of general surgeons, focusing specifically on improving the outlook for surgery as well as engaging with funders around tariffs.

In most instances where the affiliation was measured the technical report concluded:

“The distribution is not materially different between affiliated and non-affiliated surgeons. This suggests that a factor external to the affiliations is driving this clustering.”

Or

“Figures show that there appear to be some minor differences between the FCPSA and non-FCPSA physicians, but none that suggest a discernible pattern in either direction. This suggests that the clustering of the fees into the groups shown is driven by other factors, potentially again scheme rates.”

Or

“Figure 24 shows the 2014 results by FCPSA affiliation. It shows that in 2014, distributions are similar in shape, although arguably a higher proportion of the FCPSA physicians fall into the higher cost peaks.”

And

“The figures show that there appear to be some minor differences between the OSSA and non-OSSA ophthalmologists, but none that suggest a discernible pattern in either direction.”

And

“Figure 28 shows the 2014 results by OSSA affiliation. It shows that in 2014, distributions are similar in shape, although arguably a higher proportion of the OSSA ophthalmologists fall into the highest cost peak.”

Or

“The figures show that there appear to be some minor differences between the PsychMG and non-PsychMG psychiatrists, but none that suggest a discernible pattern in either direction. This suggests that the clustering of the fees into the groups shown is driven by other factors, potentially again scheme rates.”

And

“Figure 34 shows the 2014 results by PsychMG affiliation. It shows that in 2014, distributions are similar in shape, although it could be argued that the PsychMG group is more heavily represented in the later spikes.”

These findings are hardly convincing evidence, nor are the conclusions that practitioners affiliated to societies are charging higher rates for the billing codes examined.

Table 61 of the technical report shows a NEGATIVE cost implication for total cost per admission through affiliation to a society, and the technical report concludes:

- *“Surgeons affiliated to ASSA have around a 10% lower total cost per admission, although this margin is diminishing slightly over time;*
- *Otorhinolaryngologists affiliated to ENTS show around 12% higher costs per admission, although this diminished to around 8% in 2014;*
- *Consulting specialists affiliated to the FCPSA show no significant cost differentials over time;*

- *Ophthalmologists affiliated to OSSA consistently show around 2% lower cost per admission than their non-affiliated peers;*
- *Psychiatrists affiliated to PsychMG showed 12% higher costs per admission in 2010, but this margin has been eliminated over the period analysed (this may reflect the ‘catch-up effect’ outlined previously); and,*
- *Surgeons affiliated to Surgicom show varied patterns over time, which suggests no major cost differences between the two groups over time (although a trend towards lower cost in the Surgicom group may be developing in 2013 and 2014).”*

Despite these notes, the main HMI report in paragraph 214, chooses to highlight only the two societal groupings which appear to have a positive impact on costs, rather than focusing on the general trend identified that, in fact, affiliation does not seem to have an impact on increasing costs, and which, in several other examples, seems to demonstrate a decreased specialist cost per admission.

We believe this is the result of the HMI *wanting* to find certain impacts from professional society affiliations which were not demonstrated on the whole by the data.

It is these types of interpretations which, in SAMA’s opinion, regrettably bring the entire analysis into question.

9.5 Recommendations of Chapter 7

9.5.1 Establishment of a Supply-Side Regulator

SAMA is not convinced that the HMI has sufficiently demonstrated the need for the SSRH from the findings in Chapter 7.

In addition, the role described for the SSRH in this Chapter seems so administratively mundane, that SAMA struggles to see how it would address any of the issues, which this analysis in Chapter 7 has supposedly uncovered.

We are, however, in favour of a Supply-Side Regulator to manage other aspects of the supply side of the market e.g. tariff negotiations, and health technology assessments.

9.5.2 Review of the HPCSA Ethical Rules

The HPCSA exists to protect patients of medical practitioners. We do not believe the HPCSA is in any way responsible for reviewing their ethical rules from a competition perspective.

The HPCSA has, with good reason, viewed making ethical rules “more permissive” with great scepticism.

SAMA agrees that the rules could be reviewed.

However, in the context of pressure from funders and hospitals alike, it is important that the HPCSA remember that its responsibility is to protect patients.

Emphasis only on cost containment can generate its own perversities, and we have urged the HPCSA to consider the quality and incentive aspects of any changes which could result from changes to the ethical rules.

Global fees and alternative reimbursement models can carry some very perverse incentives and have to be implemented extremely carefully, particularly in a profit-driven environment.

SAMA has openly disagreed with the concept of employment of doctors by the current private sector corporate entities, with whom our members deal.

We have been particularly perturbed by the language used in submissions to the HMI to advocate in favour of practitioner employment. It is evident that the intention is to “influence”, “control” and “enforce” protocols, approaches and functions on practitioners (Table 2).

In addition there is little evidence that corporatisation of pharmacies has resulted in improved distribution of services, or improved quality of pharmaceutical care to the

population, despite promises that corporate groups made at the time this policy was being debated¹⁵.

Table 2: Stakeholder calls for employment of doctors throughout the HMI Process

Calling for HCPs to be employed:	Justification
Life Healthcare – “We would like to have the approval to employ doctors.”	“We do think it would have influence in terms of some of the qualities of care, and the cost effectiveness of that care.”
Mediclinic – “Employment has advantages as well as disadvantages, from a clinical and from a business perspective, but we believe there are more advantages that we’ve seen, and we actually feel quite positive about the model in Dubai”.	It is easier for obvious reasons in an employment model to get compliance to protocols, to develop those protocols, and to get compliance from your workforce. I have purposefully avoided the use of the word ‘enforce’ in this context.
Netcare – “In an ideal world we would like to employ doctors, in an ideal world we would like to train doctors.”	
Discovery – “The structure of our regulatory environment does not allow hospitals to employ doctors. This is an issue we think is severely problematic and should be addressed.”	The HPCSA regulations preventing the employment of professionals, and the emergence of effective multi-disciplinary teams of health professionals, should be removed. These rules serve no useful purpose, and inhibit the emergence of innovative healthcare delivery models which are flourishing in healthcare systems around the world.
<p>BHF – (Advocating for HMOs to be able to employ doctors): “Medical schemes are unable to explore alternatives such as Health Maintenance Organisations due to the stranglehold the Council has on medical schemes, as well as the prohibition on the employment by schemes of health professionals.”</p> <p>An HMO is defined as “an organization that combines the provision of health insurance and the delivery of health care services.” (Given 1994)</p>	Removing the ability of non-medical practitioners to employ medical practitioners has the consequence of driving up costs (No evidence provided). The selective prohibition on the employment of medical practitioners can potentially shutdown efforts to contain rising medical costs (no evidence provided), prevent medical practitioners from competitively engaging in the economy by choosing to be employed, and threaten the ability of the most marginalised sections of our labour force (and, for that matter, some communities) to access decent healthcare.

¹⁵ Ward K, Sanders D, Leng H, Pollock A. 2014. Assessing equity in the geographical distribution of community pharmacies in South Africa in preparation for a national health insurance scheme. Bull World Health Organ. 2014 Jul 1; 92(7): 482–489.

We believe that doctors will inevitably be exposed to conflicts in dual loyalty to employers' profit-driven motives, and their patients' healthcare requirements. We additionally believe that full employment is not necessary if other innovative business models can be explored¹⁶.

Analyses of Medicare expenditure in the United States of America have indicated that hospital-employed physicians can actually cost the scheme more¹⁷. Although this first report was conducted by a physician advocacy organisation, an earlier report by Auditors General of 16 US States argued the same thing¹⁸.

¹⁶ Price Waterhouse Coopers. 2014. Physician partnership to lead healthcare transformation: Picking the right model for your market. Available at : www.strategyand.pwc.com/media/file/Strategyand_Physician-Partnership-Healthcare-Transformation.pdf. Accessed 24/09/2018.

¹⁷ PAI. 2017. Implications of Hospital Employment of Physicians on Medicare & Beneficiaries. Available at http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI_Medicare%20Cost%20Analysis%20--%20FINAL%2011_9_17.pdf. Accessed 24/09/2018

¹⁸ Medscape News. 2014. Hospital-Employed Physicians Drive Up Costs, Say 16 States. Available at https://www.medscape.com/viewarticle/830845#vp_1. Accessed 24/09/2018.

10. CHAPTER 8: EXCESSIVE UTILISATION AND SUPPLIER-INDUCED DEMAND

SAMA is concerned about the analyses and data, which informed the conclusions of this chapter.

We have requested a meeting with the HMI to better understand the rationale for the choices of the interventions in the utilisation analysis, as well as the choices of the variables used in the logistic regression model. This meeting has, however, not been granted yet, so we have continued to analyse the data as presented.

10.1 Analysis 1 – Health Care Utilisation

This section benchmarks the levels of service utilisation versus 17 OECD countries for a selected set of interventions.

i. Countries selected

The sample of OECD countries drawn as comparators was clearly a convenience sample with very little consideration for the similarities and differences in the health systems within these countries. The sample simply included the countries, which had reported on the indicators which were needed for the five years in question.

There seems to have been no effort to ensure that the OECD countries selected for comparison are appropriate comparators for the South African private health sector.

Comparison of the South African private health market with OECD country data is also inappropriate. Many of these populations are funded by a completely different mix of publicly and privately funded systems. In addition, even OECD countries experience limitations in access geographically, waiting times, and several other features which might impact on admission rates in these countries.

SAMA would like to point out that Portugal did not meet the requirements of having all the necessary data available for the five years under study for all the interventions; caesarean section data is missing for Portugal from the OECD data as well as in Figure 8.2 of the HMI report. Portugal should therefore not have been included in this analysis.

SAMA RECOMMENDATION

HMI should proceed with caution in interpreting the findings of this section due to bias introduced by convenience sampling. In summary, the countries selected differ significantly from South Africa's private sector and implicit rationing mechanisms such as waiting periods can affect utilisation. Only Germany has a private funding model similar to SA and the utilisation rates of the two countries are similar.

ii. Interventions selected

The Panel selected cholecystectomy, tonsillectomy, inguinal hernia, cataract surgery, coronary artery bypass grafting and Caesarean section for comparison.

It is not clear to SAMA why the full suite of surgical interventions available from the OECD data were not included in the analysis.

Caesarean section admission cannot be simply adjusted for age, as in Figure 8.2.

The Caesarean section rate is surely also dependent on the underlying birth rates within the population. It should be reported for comparison, as caesarean section rate per 1000 live births. South Africa has double the crude birth rate of most of the other countries in the OECD sample¹⁹.

Only Israel's birth rate is comparable to South Africa, and they are well-known to have the lowest Caesarean section rate in the whole of the OECD group of countries.

Furthermore, Caesarean section can be indicated to reduce mother-to-child transmission rates. We believe these factors should have been considered.

Similarly, coronary artery bypass graft rates are determined by the prevalence of ischaemic heart diseases in the population. Compared to the 17 OECD countries, South Africa's mortality rate from ischaemic heart disease is higher than most countries except Germany, France, Australia, Hungary, UK, Italy and Spain.

¹⁹ <https://data.worldbank.org/indicator/sp.dyn.cbirt.in>

iii. Influences not accounted for in the OECD Analysis

Waiting times

Comparing the South African private sector to outcomes of national health systems may not be a fair comparison. Even advanced national health systems are still grappling with waiting times for elective procedures, and they are trying to find ways of improving these.²⁰

Caesarean section would probably not be affected so much by waiting times, but certainly interventions such as arthroplasty and hernia repair could be. The OECD also does not report on waiting times for tonsillectomy, hernia surgery and cholecystectomy.

Unfortunately, not all the OECD countries report on waiting times in a regular and standardised manner, so the sub-sample for this from the sample of countries presented by the HMI Provisional Report is relatively small.

At the intermediate level, sub-units such as hospitals, determine the number and mix of various providers, the extent of direct access, schedules, and waiting times for various healthcare services.

In a study conducted in 2013, the authors attempted to look at waiting times across several of the OECD countries in the HMI analysis.²¹

A majority of the countries studied monitor national waiting times and have some type of national waiting time care guarantee. This implies that waiting time is an issue of concern.

In a study from 2003 on waiting times in OECD countries, Siciliani and Hurst concluded that “waiting times” is a serious health policy issue in 12 of the countries included in that study, and several included in the HMI sample (Australia, Canada, Denmark, Finland, Ireland, Italy, Netherlands, New Zealand, Norway, Spain, Sweden

²⁰ Siciliani, L., V. Moran and M. Borowitz (2013), “Measuring and Comparing Health Care Waiting Times in OECD Countries”, OECD Health Working Papers, No. 67, OECD Publishing, Paris. <http://dx.doi.org/10.1787/5k3w9t84b2kf-en>

²¹ Viber N, Forsberg C, Borowitz M, Moline R. (2013). International comparisons of waiting times in health care – Limitations and prospects. Health Policy. Volume 112, Issues 1–2, September 2013, Pages 53-61.

and the United Kingdom). Waiting times were not recorded administratively in a second group of countries (Austria, Belgium, France, Germany, Japan, Luxembourg, Switzerland and the USA), but the authors wrote that they were anecdotally (informally) reported to “be low”.

France's lack of national monitoring is often cited as evidence that the country has no waiting time problems.

However, the large regional differences in terms of services provided and number of doctors have led to inequities in access.

In Germany, the debate has revolved around the fact that people who are privately insured have faster access to healthcare than those in the population who do not have private insurance.²² This is possibly the reality for the insured population in South Africa, so we do not consider comparing national figures to private sector figures in the South African market to be appropriate. In Austria, researchers have found that privately insured patients have faster access,²³ and they have refuted the notion that the country has no waiting times.

Sweden has repeatedly been mentioned as a country with relatively long waiting times^{24,25} but this cannot be confirmed, as it is not possible to compare to other countries using official national statistics, as Sweden does not publish these.

SAMA believes an appropriate analysis would involve comparing like for like in South Africa and the OECD countries. Waiting times will influence access to non-emergency interventions and where waiting times are reduced (as in the private sector in South Africa), admission rates will be higher.

²² Kuchinke BA, Sauerland D, Wubker A. (2009). The influence of insurance status on waiting times in German acute care hospitals: an empirical analysis of new data. *International Journal for Equity in Health* 2009 **8**:44 <https://doi.org/10.1186/1475-9276-8-44>

²³ T. Czypionka, M. Kraus, M.G.R. Riedel. (2007). Waiting times for elective operations in Austria: a question of transparency. *The Institute for Advanced Studies (IHS)* (2007)

²⁴ The Commonwealth Fund **2010 Commonwealth Fund International Health Policy Survey** (2010) <http://www.commonwealthfund.org/Content/Surveys/2010/Nov/2010-International-Survey.aspx>

²⁵ Health Consumer Powerhouse **Euro health consumer index 2009 report**.(2009) <http://healthpowerhouse.com/files/Report%20EHCI%202009%20091005%20final%20with%20cover.pdf>

The fact that elective surgeries are not performed to address emergency situations, in no way renders them medically unnecessary. Thus, reduced waiting times for these surgeries is desirable, as policies to achieve these in OECD countries demonstrate.

Mix of Public and Private Funding and insurance funding

Paragraph 9 on page 378 makes reference to the fact that all comparator countries have universal health coverage through publicly funded national health or insurance schemes. What is not noted is the vast differences between the countries in terms of the distribution of public and private funds.

Table 3 illustrates that the countries differ substantially in their distribution of funding sources. This may indicate systems with constraints such as Spain and Portugal, or some with relatively fewer constraints such as Switzerland. It also indicates that some systems are relatively well funded through private insurance funding and others are very dependent on social security arrangements, or government funded systems.

There is no clear rationale for comparison.

Throughout all the countries compared, government and private expenditure, expenditure from social security contributions, and private insurance versus out of pocket payments, varied substantially in 2012.

Table 3: Health expenditure ratios of countries included in the OECD comparator set (2012)²⁶

Country	General government expenditure on health as a % of total expenditure on health	Private expenditure on health as a % of total expenditure on health	Social security as a % of general government expenditure on health	Out of pocket expenditure as a % of private expenditure on health	Private prepaid plans as a % of private expenditure on health
Australia	67	33	0	58	26
Austria	76	24	55	65	18
Belgium	75	25	86	82	17
Denmark	86	14	0	87	12
Finland	75	25	19	75	8
France	77	23	95	33	59
Germany	77	23	89	56	40
Hungary	63	37	83	76	7
Ireland	68	32	0.2	52	41
Israel	60	40	72	65	26
Italy	77	23	0.4	83	4
Luxembourg	84.5	16.5	84	66	27
New Zealand	83	17	10	63	29
Portugal	64	36	1.7	76	14
Spain	72	28	6.6	77	20
Sweden	81	19	0	88	2
United Kingdom	84	16	0	56	17
South Africa	48	51	2.8	14	81

²⁶ World Health Organization. 2015. World Health statistics 2015. Available at http://www.who.int/gho/publications/world_health_statistics/EN_WHS2015_Part2.pdf?ua=1. Accessed 20/03/2016.

10.2 Analysis 2 – Utilisation levels – Intensive care admissions

This analysis can have little meaning without understanding what the diagnoses or admission codes are for the ICU (Intensive Care Unit) interventions.

The OECD does not publish ICU admissions data, so it is not clear to us on what basis the age adjustment was done in Figure 8.3, and no references are given for the age adjusted ICU admissions country dataset in Figure 8.4. This is a different country comparison group to the previous analysis, and we wonder why this was done; perhaps this is another convenience sample with little applied knowledge of other countries' health systems?

Also, given the burden of disease in South Africa, and the fact that trauma, motor vehicle crashes, and other injuries (all of which could most certainly result in ICU admissions), disproportionately affect younger age groups²⁷, it does not make sense to age adjust according to other countries with different causes of ICU admission and different age structures and disease burdens.

HIV infection, also considerably higher in South Africa than any of the comparison OECD countries, also disproportionately affects younger patients, and can also result in serious infections, which may require higher than normal levels of care.

We are of the opinion that Figure 8.3 is meaningless and is simply an attempt to show a “high” utilisation of ICU, which may, or may not, exist in reality.

We have a similar concern with Figure 8.4 as no adjustment has been taken into account for disease burden faced by the population, particularly given the age adjustment.

To compare for ICU admissions rate appropriately it is important to control for confounding factors that include not only age but burden of disease. This is because interpersonal violence, motor vehicle crash injuries, and HIV infections are more likely to affect younger people, and can account for high ICU admission rates.

²⁷ Stats SA: Statistical release P0309.3. Mortality and causes of death in South Africa, 2016: Findings from death notification

10.3 Analysis 3 – Supplier-Induced Demand

Within the first paragraph of this section, the HMI exposes their own biased approach in this regard.

Generally, in a research setting, the objection of analysis is that hypotheses are “tested”, not “confirmed” as is the stated intention of the analysis in statement 17. This stated, very biased objective sets the scene for the one-sided analysis, which follows.

SAMA is extremely disappointed that the HMI seems to have deliberately set out to prove that supplier-induced demand exists, rather than conducting a robust investigation to test *if* it exists.

The geographical analysis is, unfortunately, non-sensical, given that it is already established that specialists, specialist services, and the facilities in which they are delivered, are concentrated in the more urban areas of the country.

This means that patients in more outlying (rural) areas often have to access specialist care at these centres, sometimes travelling great distances from their residences to do so.

Thus, analysis at the municipality level is not appropriate.

i. Number of admissions in selected specialities: Selection of discretionary procedures

In this analysis, the Panel selected 11 specialities and identified discretionary procedures. The Panel focused on the risk of admission where there was a lot of discretion in admitting the patient. The Panel Inquiry defined “discretionary services” as services that are **non-life threatening** and **non-emergency**. This is problematic to SAMA for the following reasons:

- a. In our view, discretionary services refers to health services where there is no consensus in management of that condition.
- b. The list of interventions listed includes lifesaving interventions. See Table 4.

- c. The list of interventions include Public Health Policy interventions (such as circumcision), which makes them not discretionary. Voluntary male medical circumcision was rolled out from 2009 as an HIV prevention strategy²⁸. As the policy implementation progresses, we expect pent-up event in populations where cultural circumcision did not exist, for example, in KwaZulu-Natal. Implementation of male medical circumcision also made circumcision available for populations that practice cultural circumcision, therefore driving appropriate and safe utilisation of health services. This is a positive effect as traditional circumcision schools are associated with high mortality and morbidity. The discussion we need to be having is whether circumcision needs to be offered by specialists. Various NGOs have started training medical officers and GPs in performing circumcisions.
- d. Just because an intervention is not an emergency, or life threatening, does not mean that it is “discretionary”. An intervention may remain extremely necessary to return a patient to a status of daily normal functionality (as is the case, for example, with arthroplasty), or to biopsy a malignant tumour; removing a benign tumour which could become problematic later, or to even manage severe tonsillitis which can affect learning and future capabilities.
- e. It is problematic that all paediatric admissions are considered discretionary. This is inappropriate as causes of admissions in private sector children include pneumonia and diarrhoea. These diseases remain the top causes of mortality²⁹, and a priority for Sustainable Development Goals.
- f. It is also problematic that all psychiatric admissions are considered discretionary, and therefore contribute to supplier-induced demand. South Africa has a high prevalence of anxiety disorder, followed by substance misuse, and mood disorders. There is generally a consensus amongst psychiatrists on admission for the following conditions which are considered psychiatric emergencies and are life threatening:

- Suicidal ideation

²⁸ NDOH: Strategic Plan for the Scale up of Medical Male Circumcision in South Africa, 2012-2016

²⁹Stats SA: Statistical release P0309.3. Mortality and causes of death in South Africa, 2016: Findings from death notification

- Homicide ideation
 - Suicide attempt which can be secondary to drug or poison ingestion.
 - Self-inflicted injury
 - Danger to self and others
 - Intoxication or withdrawal delirium
 - Delirium from other causes
 - Psychotic episodes
 - Manic episodes
- g. Other non-emergency disorders which have a reason for admission where there is consensus include
- Assisted and involuntary admission as a per the Mental Health Care Act of 2002
 - Social reasons: for example, a severely demented/ psychotic patient with no care givers
 - Safety of minors who have been abused
 - Admission for diagnostic work up and further treatment where outpatient care has failed.
 - Admission for diagnostic evaluation

The design of the Prescribed Minimum Benefits is such that it emphasises inpatient care rather than outpatient care. For schizophrenia it is not prescribed to Medical Schemes that they must pay for outpatient care. As a result, some schemes do not pay for outpatient care of schizophrenia. This is despite the fact that Schizophrenia is part of the Chronic Disease List and has a gazetted treatment algorithm which allows for outpatient care for Bipolar Disorder and Major Depressive Disorder.

Apart from mandated 15 outpatient psychotherapy sessions in lieu of 21 days admission, which is a Prescribed Minimum Benefit, no scheme funds out-of-hospital mental health from risk pools. Outpatient mental health can be costly, and can result in financial ruin for families.

SAMA has advocated for financing of mental health services out-of-hospital without success. Although community mental health services are considered the best

approach, and the national strategy³⁰, even government failed to implement this approach as confirmed by the “Life Esidimeni Crisis”. This is an area where a comprehensive out-of-hospital package will reduce unnecessary expenditure.

³⁰ National Department of Health: National Mental Health policy framework and strategy. 2013-2020

Table 4: SAMA comments on list of discretionary procedures

Model/discipline	Discretionary Procedure	SAMA comments
Cardio Thoracic Surgery	Coronary artery bypass graft (CABG)	
Cardiology	Diagnostic ultrasound of heart (echocardiogram)	Echocardiogram is indicated for a variety of heart conditions including assessment of left ventricular functioning in heart failure, evaluation of heart valves, evaluation of implantable devices, and evaluation of causes of thromboembolism. The list is very long, and the HMI cannot conclude that this intervention is discretionary when it has Class I indications for some conditions. We recommend the following website to validate information: http://asecho.org/ase-guidelines-by-publication-date/
	Percutaneous transluminal coronary angioplasty (PTCA)	PTCA is indicated as a gold standard treatment in patients with ST-ELEVATION MYOCARDIAL INFARCT. It is also indicated in patients with HIGH RISK acute coronary artery syndrome. Therefore this is not a discretionary procedure as per HMI recommendations.
	Diagnostic cardiac catheterization; coronary arteriography	As above
Neurosurgery	Colonoscopy and biopsy	This is an appropriate intervention for neurosurgeons.
Orthopaedics	Spinal fusion	No comment
	Bunionectomy or repair of toe deformities	No comment
	Arthroscopy	No comment
	Excision of semilunar cartilage of knee	No comment
	Arthroplasty knee	No comment
	Hip replacement; total and partial	No comment
	Arthroplasty other than hip or knee	No comment
	Injections and aspirations of muscles; tendons; bursa; joints and soft tissue	No comment
Otorhinolaryngology (ENT)	Tympanoplasty	No comment
	Myringotomy	
	Plastic procedures on nose	
	Tonsillectomy and/or adenoidectomy	Not an emergency or lifesaving procedure but necessary for child

		development.
Paediatrics	All paediatrics procedures	Not true
Psychiatry	Psychological and psychiatric evaluation and therapy (no further diagnostic information was available for psychiatric admissions)	Not all psychiatric admissions should be considered discretionary.
Surgery	Varicose vein stripping; lower limb	Truly discretionary
	Upper gastrointestinal endoscopy; biopsy	May be indicated as an emergency and lifesaving intervention when upper GIT bleeding is suspected.
	Proctoscopy and anorectal biopsy	
	Haemorrhoid procedures	
	Cholecystectomy and common duct exploration	
	Inguinal and femoral hernia repair	There is no discretion in management of obstructed hernia
	Other hernia repair	As above
Urology	Transurethral resection of prostate (TURP)	It is indicated for Benign Prostate Hypertrophy with urinary tract obstruction. Generally there is consensus among urologists for this condition. It can also be used when a patient opts for brachytherapy and the prostate is slightly large. There may be some discretion here.
	Open prostatectomy	Indicated for localised prostate cancer, together with brachytherapy. The costs are almost similar.
	Circumcision	This is not a discretionary procedure, it is national policy.

ii. Selection of specialities

There is also absolutely no justification given for the disciplines chosen for the analysis other than that they “have high rates of discretionary admission (see previous paragraph). Having discretion over admission in no way means it is not medically necessary nor not important.

The HMI has not defined what they mean by “greater discretion” which becomes even more confusing when the actual disciplines are separated by proportions of their admissions, which are considered “discretionary”.

Figure 8.7 is a graphical presentation of the total versus discretionary admissions in selected specialities. Is not *normal* that all cardiology, urology and cardiothoracic admissions are discretionary.

For cardiology it means that cardiologists only admit for three interventions in HMI Table A 8.2, i.e. Echocardiogram, percutaneous interventions and angiography. Similarly, urologists admit for TURP, circumcision and open prostatectomy, whilst cardiothoracic surgeons only admit for coronary artery bypass graft.

This does not make clinical sense and warrants further interrogation.

iii. Distribution of specialists

Figure 8.8 is a biased representation of the distribution of specialists throughout the country. All zero counts have been excluded which means it is not possible to view municipalities which have *no* specialists in a particular discipline, which we would believe to be many out of the 234 geographies.

This municipal analysis demonstrates a genuine and fundamental lack of understanding of the functioning of the private health sector by the team of analysts. SAMA is disappointed in this over-simplified approach.

What Figure 8.8 demonstrates is that, in many specialist disciplines, the median and even maximum number of specialists per 100 000 population to be served (even given the miscalculation because of the ill-applied municipal boundaries) is extremely low.

Doctors do not need to generate demand for their services; there is an undersupply of doctors and a demand beyond that which most services in municipalities can cope with.

10.3.1 Analytic Methods – Logistic Model

The description of the design of the logistic regression model is truly disturbing, and we believe we can help the HMI identify why the model has such a poor fit to the reality.

It is common knowledge that the inclusion of too many variables in a regression model are likely to have the result of a poor fit.

It is also understood that any model is best designed using strong theory of the independent variables which are likely to be influencing the dependent variable.

It appears to SAMA that the designers of the HMI model simply took everything at their disposal from the useable data they had, and tried to squash it into a model, resulting in gross mis-specification, poor fit, and poor predictive value of the models.

Key rules for the evaluation of a regression model include:

- Is the equation supported by sound theory?
- Does the estimated regression fit the data?
- Is the dataset reasonably large and accurate?
- Is logistic regression the best estimator for to be used for this equation?
- Are all the obviously important variables included in the equation?
- Have all the unimportant variables been removed as far as possible?

As the equation and independent variables seemed to remain the same regardless of the outcomes (Model 1 and the various outcomes of Model 2) – it seems safe to surmise that many of the rules above have not been adhered to with regard to the design of the logistic model.

In addition, it is apparent that several of the predictor variables are *not* independent of each other. For example, years since joining the scheme, and membership months, are directly related to each other.

We note that the Panel tried to expand burden of disease to include the wider scope.

It is our view that significant causes for admission have been omitted. In the NMG Expenditure Analysis Report 5 (July 2018), *Table 36: In-Hospital Consultations per 1 000 Lives Trends by Diagnosis Group, 2010-2014*.

The top 15 causes of in-hospital admission include trauma, and complicated and uncomplicated maternity.

These conditions were not included in the regression model.

Given the existence and increase of multi-comorbidities in the medical schemes population, many of the chronic conditions in the model would affect many patients simultaneously and are thus not strictly independent of each other.

This has not been addressed nor dealt with in the modelling.

As far as beds per 100 population, and practitioners per 100 population is concerned, we have already explained that patients from more outlying areas frequently need to seek care in more urban centres, so these variables are miscalculated from the outset, as the denominator used for population catchment areas is incorrect.

We note that although a scheme plan is listed as a predictor variable, it does not seem to have been presented in any of the results figures.

What became of this variable in the model?

10.3.2 Analytic Methods – Model 1: Overall Hospitalisation Model

SAMA notes that the effect sizes of chronic disease on admission are far larger in many instances than any influence of other factors, other than advanced age. This makes perfect sense.

Our interpretation of the influence of the supply of doctors is that we would expect to see increased admissions where admitting doctors are present.

We are not sure how the HMI draws a causal supplier-induced demand relationship from this information.

The model fit presented in HMI Table 8.1 is, too poor to be considered of any value, and indicates the concerns, which we highlighted earlier about the fact that the model has been poorly specified in the first place.

Making excuses for the fact that the R squared statistic is low is a poor way to address this problem, the statistic is there to check the fit of the model to the data.

This model does not fit the data.

SAMA is concerned by the truly ambiguous statement on page 391 of the Report: “We conclude that these findings support the existence of supplier-induced demand but cannot be seen as conclusive.”

Yet, the report seems to have concluded that there is supplier-induced demand in operation in the private sector.

This is inappropriate from a body such as the Competition Commission and inappropriate given the recommendations, which are made in the basis of this analysis.

10.3.3 Analytic Methods – Model 2: Speciality Specific Models

Given that there is so much wrong with the model overall, it seems unlikely that it will do much better to approximate the situation in the specialities. The model remains poorly specified, even when applied to specialities.

The presence of chronic diseases seems to be as strong a determinant in admissions for both all admissions and discretionary admissions in all the specialist models. Once again this is not surprising.

We would expect that where doctors *are* available, there would be admissions of patients from outside the municipality concerned, so we are not sure that the positive and significant relationship between doctors per 100 000 in the municipality, and the number of admissions, which includes patients from outside this geographical border, has any relevance at all.

We note that the total admissions and discretionary admissions models were very similar and this is described as unsurprising. We are then forced to ask why it was necessary to separate these two analyses in the first place.

10.3.4 Analytic Methods – Childbirth Model

Given the specific clinical determinants of Caesarean section delivery and the specific variables that *should* have been included in a model of this nature, we are also not surprised to see that this model also has a bad fit for the outcome (pseudo R squared of 6%).

Clinical indicators for Caesarean section delivery include previous Caesarean section, multiple pregnancy, HIV infection (albeit debatable) amongst others.

Women are also likely to request Caesarean section despite clinical indications. We suspect that women who plan to deliver with Caesarean section will more likely purchase higher option plans. Therefore, option plan should have been included in the model.

It is also not acceptable that conditions that are not predictors for Caesarean sections such as arthritis, back problems etc. *have* been included in the model. Conversely, conditions where Caesarean section would not be indicated as an automatic mode of delivery such as anaemia, blood disorders, and acute respiratory ailments were included in the model.

10.3.5 Analytic Methods – PMB and Non-PMB Conditions

Having already highlighted the poor fit of the model, we are not going to waste time examining this analysis, it is too meaningless to do so.

The assumption that PMB equals non-discretionary, and non-PMB equals discretionary does not hold true, yet these terms seem to have been made equivalent by whoever constructed the model.

This is evidenced by the statement on page 397, “For doctors, however, the effect on non-PMB diagnosis is significantly larger, confirming that supply-induced demand is more prominent for more discretionary interventions.”

10.4 Comments on the Conclusions from the Multivariate Model

SAMA is disappointed that the HMI would try to make any conclusions based on the inappropriate modelling, which has been conducted in this regard, including a poorly specified model, which endangers the entire analysis.

We do not agree, given the fact that the analysis is municipality population based, and given that chronic diseases apparently seem to have much larger effects on admissions, that the conclusion does not mention these factors at all. It is as if burden of disease does not matter at all.

Similarly, there are various recommendations that are based on this Chapter, which invalidates the HMI commitment to evidence-based recommendations.

11 CHAPTER 9: OUTCOMES MEASUREMENT AND REPORTING

SAMA is pleased at the level of emphasis placed on the need for better information collection, and transparent sharing of outcomes data in the HMI report.

SAMA made submissions in response to the proposals for the discussion document: “Health outcome measurement and reporting: Improving the cost and effectiveness of clinical care in a competitive private healthcare sector in South Africa”, published on 28 August 2017.

In measuring quality, it is important to note that three sets of indicators are used, namely *structural, process and outcomes* indicators. These can be significant determinants of each other (i.e. structure and process contribute to outcomes).

The best quality monitoring body should be able to monitor all these indicators. We know structural indicators can predict outcomes such as mortality or disability. Improvements in structure are essential in improving outcomes. Process indicators can be collected annually and offer an opportunity for improvement before realisation of improvement in outcomes. If one body monitors these three indicators, quality improvement measures can be implemented and enforced.

SAMA was not in support of establishing a completely new statutory body – the Outcomes Measurement and Reporting Organisation (OMRO) – as envisaged in the discussion document.

Our reasons were as follows:

a) Such a body is at risk of redundancy i.e. becoming yet another addition to the long list of currently inefficient and struggling statutory bodies such as the National Health Laboratory Services (NHLS). In addition, the stated mandate of the OHSC already has some overlaps with the envisaged functions of the intended independent body.

b) The body will demand enormous financial and human resources from the already under-resourced national reserve. Experiences from other countries show that registries cost a lot of money to establish and run, and take years to come out with any decent answers. Instead of establishing a new body, focus should be placed on enhancing the current quality regulatory system by expanding the capacity and

mandate of the OHSC or Council for Medical Schemes. During the NHI White Paper submission period, SAMA, in its submission, doubted the independence of the OHSC. Therefore, part of strengthening the OHSC should include building in strong accountability mechanisms into the OHSC.

Expanding the mandate of the OHSC may also need to entail renaming the OHSC to remove the imbedded focus on 'compliance', to include the broader roles including defining outcome indicators.

12 CHAPTER 10: RECOMMENDATIONS

SAMA does not believe the HMI has managed to demonstrate supplier-induced demand based on the analysis, which we have examined.

The analysis was fundamentally flawed and conducted on poorly specified models, with bad fits to the data, and hence many of the conclusions drawn on the basis of these models are incorrect, and, SAMA believes, fundamentally misleading.

We also do not believe that the HMI makes a fair argument against professional associations. Indeed, the analysis conducted in an attempt to show that affiliated members charge more than their non-member peers failed to show a general trend in this direction.

We consider that the HMI used the single outlier in this analysis in an attempt to make its case against professional associations. This is a disappointing conclusion by the HMI, but we believe in line with several other assertions, which have been falsely made throughout the document regarding medical practitioners.

Unfortunately this taints all the recommendations which the HMI has made, supposedly based on the “evidence” it has reviewed.

There are, however, some recommendations, in particular where the HMI encourages the full and proper implementation of existing legislation, which SAMA agrees with.

12.1 Funders

SAMA is disappointed that the recommendations relating to funders are on the whole extremely weak and address, for the most part, existing legislation which has simply been poorly implemented by a regulator which we consider to be failing in its mandate to protect the interests of medical scheme members.

The HMI seems to have overlooked the major competitive issue in this space. These are the issues identified and which require specific recommendations:

- a. Oligopolies within the Administrators and Managed Care space: the high dominance of only a few administrators, and the actions, which they take with impunity, which are not in their beneficiaries' interests.
- b. Cross-ownership and Cross-directorships: There is evidence that this exists; although the HMI found that the behaviour is non-competitive there is a future risk. We believe the HMI should have proposed a mitigation strategy.

Recommendations for risk adjustment are not new, nor are recommendations for more frequent reviews of benefit packages, both of which have been in the regulatory policy trajectory for some time.

Recommendations for incentives to encourage younger members to join medical schemes through a discounted premium process are welcomed, but were already promulgated in the Medical Schemes Amendment Bill ahead of the HMI report being published.

On the other hand, we do not believe that the models were able to confirm that there was anti-selection, even if they are a poor-fit. We thus do not support proposed underwriting mechanisms as they would further disadvantage the less privileged, i.e. those who have suffered economic exclusion in the apartheid era and those who face high unemployment rates.

12.2 Benefit package

SAMA supports the implementation of standardised obligatory-based packages, which will include catastrophic, primary healthcare, and preventative packages. We believe hospital plans and a hospital-centric PMB package is partly to blame for inappropriate hospitalisation, therefore making hospital plans obsolete is acceptable.

We also support recommendations on supplementary benefits, which should be standardised across schemes. However, we do not believe that supplementary benefits need to be risk-rated, nor be exempt to tariff negotiation. This would result in gaming by the schemes, doctors and hospitals.

SAMA supports proposed recommendations to improved governance of schemes.

12.3 Brokers

SAMA is pleased with recommendations 54 and 55 relating to changes to the current broker system.

Our membership feels that brokers are currently the weakest link in the market, advising patients poorly (if at all), and often incorrectly for their needs. The accusation is that broker advice is tainted by fees paid to brokers rather than genuine benefit for members.

12.4 Hospitals

SAMA recognises the highly concentrated nature of the private hospital environment in South Africa. We, however, disagree with the funders' concerns that the "must have" nature of the hospitals "reduces funders countervailing power". Given the concentration in the funder environment, and the perversities identified in this environment, SAMA doubts that the HMI should be looking at mechanisms to enhance the power of the funders.

We recognise challenges in the licencing regime for hospitals (and made submissions on this in December 2017 in response to a call for submissions). The suggestion that funders be involved in the assessment of hospital applications, however, is extremely unwise, and potentially damaging to the interests of medical scheme members.

If a consistent methodology can be designed and a transparent and consistent approach applied, this should not need to involve funders. Also, the statement that funders have an in-depth knowledge of health dynamics (implying hospital groups and other participants in the market do not) amounts, we believe, to siding with the funder groups, which is disappointing.

SAMA agrees that supply-side regulation is fragmented, with little cooperation. However, we believe the HPCSA ethical rules have been developed with the best intentions for the protection of the patients which practitioners serve, the primary aim to minimise the opportunity for perverse incentives to creep in.

Many of the alternative reimbursement regimes proposed to providers by medical schemes, hold significant potential for perversity and practitioners approached who

recognise this do not wish to participate. Many of the proposed alternative reimbursement models from scheme are driven by a cost-saving imperative, and we have encouraged our members not to participate where they believe there are incentives to compromise quality of care to patients.

SAMA is not, however, against the reform of some of the ethical rules, *if* the intention is to facilitate models of care delivery, which serve the interests of the patients and scheme beneficiaries.

SAMA is also in favour of the establishment of a dedicated Supply-Side Regulator. However, we are concerned that it may become a large, ineffective, lumbering bureaucracy, as we have experienced with several other regulators in the healthcare market.

We would welcome the existence of an effective body to assist the country in achieving the four critical pillars.

Capacity planning has suffered tremendously in the country, was not addressed by the Human Resources for Health Plan of 2012, and would be an area, which SAMA would be keen to support.

Capacity planning will have to stretch across both public and private sectors if it is to be effective. We believe that the HMI's recommendations for capacity planning are too simplistic and limited, although we recognise that this was not part of the HMI's mandate.

12.5 Facility licencing

SAMA has expressed its views on the issuing of certificates of need to facilities in a submission to the HMI, as well as in public previously. We do not believe it is the best mechanism to achieve improved distribution of health services, nor, unfortunately, that it is likely to be implemented in such a way that it improves access to healthcare services.

We believe, however, that the licencing regimens can be improved and made more transparent, and agree with the consideration factors as listed in the recommendations. We also believe making the statistics on the number of beds,

operating theatres, and intensive and high care units available across the country, will be useful for capacity considerations.

It is not clear yet what the role of the Provincial Departments of Health will be in relation to the SSRH, or how this regulator will be any better than the current Department of Health to ensure that provinces remain accountable for their reporting and regulating duties. It is also not clear what these will look like under the National Health Insurance model to be implemented.

Recommendation 79, which is the suggestion for a moratorium placed on the three large hospital groups' being granted licences is completely self-defeating, and not in the interests of access to healthcare for the citizens of the country. If these groups are the only ones who have the capacity, or ability, to open facilities in less well-served areas, and are willing to do so, then there should be no obstacles to them doing so.

SAMA is surprised similar recommendations were not made for medical scheme administrators, if it is in the power of this HMI to do so.

Recommendation 82 will result in no new licences being issued. The OHSC is a standards authority, which assesses and the performance of facilities with regard to staffing, processes, quality measures, and clinical abilities, etc. Facility licences are often issued *before* a facility is even built. The OHSC is thus not able to assess quality standards of the facility, which does not exist yet.

Therefore, we are comfortable that the OHSC could be involved in assessment of facilities for re-issuing of licences, but it is not possible for it to certify new or planned facilities, before they are operational.

The functions of a licence and a certification process will inevitably have to be separate in these instances.

In addition, the OHSC appears even to be able to cope with the requirements of inspecting public sector facilities, and certainly seems not to have been able to make significant inroads into the quality of care offered in these institutions.

We would thus be cautious about the OHSC assessment as criteria to certify a facility for approval for a facility licence for the foreseeable future.

12.6 Practice Code Numbering

SAMA is delighted to see that no fees are to apply to the new proposed practice numbering system. Practitioners have been funding the current PCNS (practice code numbering) system through annual fees paid to the BHF (Board of Healthcare Funders), and we are pleased at the suggestion that other criteria will now determine the issuing of a practice code number.

Once again the circular logic for the OHSC to certify a new facility or practice applies; a licence will be required first and *then* the OHSC inspection can be part of a process for renewal of licences.

12.7 Economic value assessments

SAMA is fully supportive of the better development of standards of care, evidence-based treatment protocols, and health technology assessments.

12.7 Health services monitoring

SAMA is also in support of the improvement of health services monitoring as well as the development of a standard system to do this.

12.8 Health service pricing

SAMA believes that a return to a collective bargaining mechanism will be beneficial, but only where power imbalances between the various stakeholders can be addressed.

We have addressed this point, but there is little evidence to back up the concern highlighted by the HMI regarding medical associations negotiating on behalf of their members, as stated on page 25 of the Recommendations Chapter.

We believe that the HMI has reported the results of the professional association analysis incorrectly and not highlighted what it actually showed – that for most professions, there was little difference between rates billed by professional association members and those who were not members.

This analysis clearly showed clustering around the tariffs set by the major funders, which already demonstrates that doctors are price takers in this environment. Why hospitals and medical schemes would be able to be represented, and collectively bargain, but professional associations are problematic in this instance, is not clear to SAMA.

It is unlikely that attempts at multilateral negotiations will be successful unless there is some acceptance that a group of providers will also be represented by a smaller number of individuals, just as schemes and hospital groups are.

SAMA would be in favour of Proposal 2: Multilateral tariff negotiation, and the multilateral tariff negotiation forum, for several reasons:

- It is a more transparent process
- The stakeholders can ensure they are best represented in discussions
- There is opportunity for discussion and debate and settlement on tariffs, which are acceptable to all

12.9 Establishment of an independent Supply-Side Regulator

SAMA would support the establishment of the Supply-Side Regulator, as well as its roles and functions as envisioned in Figure 10.1. We are, unfortunately, concerned that it duplicates many of the functions which are supposed to reside at the National Department of Health, or which will *also* exist within the National Health Insurance structures. There are multiple duplication issues as far as functions with the committees envisioned by the NHI, which will overlap with the new SSRH.

Other areas of duplication include PCNS, which currently is the CMS Mandate. Despite the duplicative role, the SSRH can play a vital role. It is our belief that health technology assessment (HTA) and guidelines development should never be the function of the funder: the funder can be government or private medical scheme. For example: National Institute of Clinical Excellence in the UK is an autonomous body responsible for the development of guidelines, completely independent from the NHS, which is the funder.

12.10 Practitioner Payment Models and Coding Systems

Regrettably, the language used by the HMI in this section is the same as that used in medical scheme rhetoric and SAMA feels the HMI has overstepped its mandate going into these models.

Even in the Fee-For-Service model, funders are able to set the tariffs they pay for interventions, so the implication that funders are some sort of victims in the current system may be inappropriate.

Patients unfortunately often bear the brunt of the gap between scheme rates and what practitioners charge, however, and SAMA has also been exploring the features of alternative reimbursement mechanisms, which can limit patient exposure and improve quality of care.

A handwritten signature in black ink, appearing to read 'Mzukisi Grootboom', with a horizontal line underneath.

Dr Mzukisi Grootboom
SAMA Chairperson