SA Heart

SASCI
South African Society of Cardiovascular Intervention

SUBMISSION BY THE SOUTH AFRICAN SOCIETY OF CARDIOVASCULAR INTERVENTION ("SASCI")

HMI Tariff Determination ("TD") Project

20 October 2017

1. INTRODUCTION

SASCI welcomes the opportunity to participate in this part of the Health Market Inquiry (HMI), addressing the issue of price determination. It has noted the HMI's document on this regard, as well as the submissions made on Friday, 13 October 2017, by various stakeholders on this matter.

SASCI's views on the specific TD matters are outlined below.

As a matter of background, SASCI wishes to raise the following as relevant to the current HMI project, as it shows how the fixation on line items and specific codes and tariffs are frustrating to doctors, and possibly not in the best interest of patients:

1.1. Number of cardiologists in South Africa

The Department of Health's Human Resource of Health 2012/3 – 2016/7 document stated on its release that there was a shortage of 70 cardiologist in 2012. According to SASCI there is currently only around 200 cardiologists, of which 12 works in the public sector. It has been reported that South Africa's ratio of cardiologists per population lags that of Senegal, which has ratio of 1:176,000, whilst South African has a ratio of 1:280,000.[1] The shortage of cardiologists gets far worse where paediatric cardiologists are concerned.[2]

Table 4.5: The ten leading underlying natural causes of death, 2013–2015*

Causes of death (based on ICD-10)	2013			2014			2015		
	Rank	Number	%	Rank	Number	%	Rank	Number	%
Tuberculosis (A15-A19)**	1	41 904	8,8	1	39 495	8,3	1	33 063	7,2
Diabetes mellitus (E10-E14)	5	23 133	4,9	3	23 966	5,0	2	25 070	5,4
Cerebrovascular diseases (I60-I69)	4	23 158	4,9	2	24 131	5,1	3	22 879	5,0
Other forms of heart disease (I30-I52)	6	22 189	4,7	4	22 928	4,8	4	22 215	4,8
Human immunodeficiency virus [HIV] disease (B20-B24)	3	23 825	5,0	6	22 729	4,8	5	21 926	4,8
Influenza and pneumonia (J09-J18)	2	24 345	5,1	5	22 813	4,8	6	20 570	4,5
Hypertensive diseases (I10-I15)	7	17 104	3,6	7	18 319	3,9	7	19 443	4,2
Other viral diseases (B25-B34)	9	14 101	3,0	9	14 508	3,1	8	16 097	3,5
Chronic lower respiratory diseases (J40-J47)	10	12 384	2,6	10	12 690	2,7	9	12 667	2,8
Ischaemic heart diseases (I20-I25)	...	...	...		...	...	10	12 239	2,7
Intestinal infectious diseases (A00-A09)	8	16 163	3,4	8	14 795	3,1	...	...	....
Other natural causes		207 523	43,6		207 593	43,7		202 840	44,1
Non-natural causes		49 681	10,4		50 692	10,7		51 227	11,1
All causes		**475 510**	**100,0**		**474 659**	**100,0**		**460 236**	**100,0**

*Data from 2013–2014 have been updated with late registrations/delayed death notification forms processed in 2015/2016.
** Including deaths due to *MDR-TB* and *XDR-TB*.
... Category not in top ten.

Given the prevalence of cardiovascular diseases in South Africa, this shortage is problematic, and would also affect the availability of services for this important field. Many prescribed minimum conditions are cardiovascular in nature, with hypertension, as a risk factor, as *the* most prevalent condition amongst medical scheme members. The country's burden of disease is reflected in the Statistics SA Mortality Report, 2017, with other forms of heart disease at no 4, and ischaemic heart disease at no 10.

[1] https://africacheck.org/reports/sa-nigeria-fewer-cardiologists-populations-senegal/.
[2] http://www.sabc.co.za/news/a/e59438804a59f1539cfcdf6d39fe9e0c/SouthundefinedAfricaundefinedlacksundefinedcardiologists-20152610.

Information on burden of disease (i.e. healthcare needs) and providers is vital to determine the reasonableness of tariff determination structures. The Constitutional Court has ruled in the *NewClicks* case[3] that healthcare access is not only about affordability (the objective of most schemes, and the DoH, so it seems), but also about availability of the services. Therefore, the unintended consequences of certain models of TD, such as price setting, must be considered. At par 315 the Court ruled:

"An appropriate fee is thus one which at least strikes a balance between cost and availability."

1.2. SASCI's oral submission and its implications for TD

SASCI made an oral submission to the HMI on 18 February 2016, and its submission on medical schemes managed care / administration entities asking "silly questions" on obvious medical issues, lead to questions being asked of medical scheme entities as to who actually manages their managed care. Although most answered that it is "**qualified healthcare professionals**", it must be understood that not all qualified healthcare professionals are authorized by their registration to make pronouncements on all healthcare matters. In particular where specialized healthcare is at stake. This is relevant in (a) the context of value-based pricing and (b) where coding is concerned.

Value-based models such as those of PPO-serve, and other models that work on outcomes, have not been embraced by most medical schemes, who appear to be focused on shorter-term immediate price controls and whose aims do not appear to align with those relating to outcomes, and where the current system of "price control per item" (whether services or products), drives the managed care market who charges for each item thus controlled.

In terms of **coding**, and coding disputes, the staff employed by funders are important. Codes give expression to professional activities, and is intrinsically related to scope of practice, and understanding the specific medical field. The SASCI survey (see below) confirmed that there is a huge gap between, on the one hand, funders and their staff, and their evaluation of care and costs, versus what the profession would understand as reasonable within their scope of practice. This goes to the heart of value-based pricing – it may be far easier for schemes to run sophisticated software programmes to pick up spikes in coding, to do pre-authorisation based on pre-set coding combinations, to enforce formularies or device choices, rather than to substantively evaluate care, within the realm of evidence-based medicine as practiced in a particular profession.

1.3. SASCI survey

SASCI has also shared with the HMI the outcomes of its survey. The main results merit revisiting in the context of TD.

1. *Practitioners that participated are, for the most part, experienced professionals, 75% having been in practice for longer than 11 years.*
2. ***Medical scheme reimbursement or RPL / NHRPL levels** are used as a **de facto price reference** by **91,7%** of participating practices.* This means that medical schemes are in effect setting tariffs being charged.

[3] *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others* (CCT 59/2004) [2005] ZACC 14; 2006 (2) SA 311 (CC); 2006 (1) BCLR 1 (CC) (30 September 2005).

3. ***DSP / preferred provider uptake is surprisingly high*** *(58%, driven by fear of patients being channeled away or fact that patients cannot afford co-payments).*
4. *Contact with medical schemes* ***rarely or never involve access to qualified medical practitioners*** *and other healthcare professionals, with more than 90% of respondents reporting they had never spoken to a cardiologist at a scheme / administrator.*
5. *In difficult or complex cases,* ***scheme approval processes mostly take longer than a week****. This result is in direct contradiction to what funders attested to during the verbal hearings.*
6. *When their matters are referred by schemes or administrators for second opinions, the identify of those practitioners are, mostly, not known.*
7. *In interaction with a scheme, some respondents give up when they do not make headway, with others trying a couple of times before telling the patient that they were not successful.*
8. *Medicines deemed appropriate by the cardiologist appear to be declined in about half the cases.*
9. *For typical treatments used in interventional cardiology, the ease of obtaining reimbursement of such care appear inconsistent.*

2. COMMENTS ON TD AND STAKEHOLDER INPUT

2.1. Rationality of approaches to TD

The Towers Watson Initial Cost Attribution Report of 1 December 2016 stated (where tariffs included not only doctors, but also hospital tariffs, costs of consumable and drugs) (emphasis provided):

Somewhat surprisingly, however, ***given that tariffs have not increased much above CPI****, there was a significant increase in the average cost per admission (~2% unexplained increase per annum).*

Given this finding, to focus on tariffs appear to not be consistent with the HMI's commissioned research.

The fact that the remainder of the Towers Watson Reports were unfortunately not completed also weighs heavily on the TD debate. These reports would have ensured a much more informed opinion as to the above inflation cost drivers in health care, and whether systems of tariff determination would be a constitutional, i.e. amongst others therefore a rational, approach to addressing those cost drivers.

What is also significant is that it means that the cost structures of providers are being questioned, and thereby its pricing, and now being placed under threat of price regulation (price setting or price caps), whereas **medical scheme stakeholders (in particular the for-profit sector operating therein), have not be subjected to this scrutiny**. For example, medical scheme administration costs have increased by 8.5% to R14.1 billion in 2016 (CMS Annual Report 2016/7). Added to that are costs of managed care, and the much-publicized principle officer salaries and trustee remuneration.

Close to every single stakeholder during the seminar on 13 October raised the issue of utilisation, and that utilisation will not be addressed by tariff setting, whichever form it takes. Indeed, many stakeholders (and SASCI also holds this view) confirmed that setting tariffs at unreasonable levels might not only have an impact on whether service providers and products are available, but that only focusing on price (and not on volume and value as well), might lead to even greater increases of utilisation. In this regard, the experience with the medicines SEP, as highlighted during discussions in terms of shifting of revenue sources (in the cases of hospitals), and the limited impact on the overall budget (in the case of medical schemes) is illustrative. The SEP is also an example of how a rigid system of fixed prices may hamper innovative healthcare delivery models.

It is therefore not clear what the main competition, scientific or economic rationale would be for TD of provider groups. This creates confusion, as the rationale for price regulation has not been agreed to. It was hoped that the remaining Towers Watson reports (on the PMBs, specialists, hospitals and medical scheme administrators) envisaged by the HMI would have provided some light in this regard.

It does appear that some of these varied reasons proposed as driving price regulation relate to:

- Allegations that funders have a **blank cheque obligation for the PMBs**. This in turn is underpinned by a belief that the current 54% of total *risk* benefits paid to PMBs are too high (CMS Annual Report 2016/7). It is never asked why this is too high, and why the focus is on this 54% and not on the remaining 46% of *risk* benefits, or other (non-risk) benefits? Is the objection against the PMBs, or against the fact that certain benefits are mandatory? Do schemes want a greater discretion in terms of benefits and limitations thereto? If PMBs are supposed to be the safety net to prevent persons from being dumped on the public sector and address the SA burden of disease, should the PMBs not be closer to 75%, or 80% of risk benefits? SASCI's survey shows that practitioners peg their fees in any event with reference to scheme tariffs, so it has not seen any systemic and scientific proof of this blank cheque.

- The need to control prices **in order to incorporate the private sector into a future National Health Insurance** system at lower unit costs. If the PMBs are changed, as is proposed, to "baskets of care" (and not diagnosis-based care), funders would only have to pay for the service costs, and not for the complete care of any condition. This would also curb utilization.

- There is a **belief that practitioner costs, and in particular specialist costs, are too high**. SASCI has not seen any evidence to that effect, and, during the HMI processes what was provided was at most anecdotal (e.g. on code unbundling) or related to utilization but with no evidence of that being the result of the tariff. In this regard the submission by Medscheme that they deem the so-called "base tariff" also questionable is noted. If the "base tariff", and even the CPI-related increases are questioned, some discussion and agreement must emerge as to why this is the case.

- **No other component of the private healthcare sector** has been proposed to be subject to price regulation, even in light of concerns raised in relation to the value added by managed care, or whether medical scheme administrators optimise scale by lower pricing.

2.2. Department of Health's approach

SASCI does not support an over-arching, all-encompassing tariff setting process as is proposed by the Department of Health. It is unlikely that the failings of the RPL process will be overcome, as the fundamental belief appears to be that practice cost studies are not a reflection of what an efficient practice would look like. So, there appears to be a fundamental difference between actual practice costs studies (on which providers would want to be remunerated and on which benchmark tariffs could be set), and adjusted practice costs (what the department believes an efficient practice should be costing). This is exactly the issue that led to the dispute between the pharmacists and the Department that resulted in the NewClicks case.

The DoH tariff will also not compensate for experience, skill, super-specialisation or other factors that vary across regions, population profiles and the likes. It also seems that, unlike the RPL, which was a benchmark tariff, the department wishes to set the tariff. This would necessitate legislative change (through an Act of Parliament), which would take another two to five years. A benchmarking process (to cover situations not governed by bi-lateral agreements), could be embarked upon with only regulations needed.

Most stakeholders appear to be wary of political interference, or interference for political, or even policy, reasons (e.g. to set tariffs in a manner to "prepare" the private sector for NHI). SASCI agrees with the views of those stakeholders that, if a benchmark process is embarked upon, the structures should be reflective of the principles of scientific validity, independence and impartiality.

SASCI also supports the proposals by Prof van den Heever and others, that where collective agreements are reached on a bi-lateral level outside of the tariff determination structures, such agreements would supercede any tariff determined by the "national" process.

2.3. Alternative reimbursement models (ARMs)

SASCI is in favour of reimbursement models where professionals take charge of clinical decisions and the outcomes thereof, and are remunerated for taking on that risk, as well as in co-operating with hospitals and other providers to ensure cost-effective, quality care.

SASCI has embarked on a few initiatives with funders to ensure cost-effective, quality care, but the field remains largely unexplored. **These opportunities should be exploited before a process of price-capping or price-setting is embarked upon.**

The legal impediments in terms of the HPCSA ethical rules on sharing of fees (ethical rule 7), business models (ethical rule 8) and sub-contracting (ethical rule 18), can easily be overcome through a change in the regulations under the Health Professions Act that contain these rules. Where there are fears of over-, under- or inappropriate servicing of patients, formalized peer review processes, as well as making all such ARMs subject to clinical scrutiny on its impact on patient rights, including outlier (complex) patients.

2.4. Coding

SASCI is of the view that professional codes should not be up for negotiation, or collective agreement. Such negotiations and agreements taint the codes with commercial interests, whether it is amongst specialists or other groups, or with funders.

A Code is reflective of a professional activity. Only persons who are duly registered at the HPCSA (or another statutory board for that matter), within a specific professional category, are allows to practice, in terms of section 17 under the Health Professions Act, 1974. "To practice" means to render professional services. Any code therefore, that gives effect to professional activities, and weigh them against each other on complexity, risk, duration and the likes, falls within the ambit of such professionals. **Clarity in coding should therefore result on the authority of the Health Professions Act**, and if abuse is expected, that should be a function of a dedicated team at the HPCSA au fait with the practice of the professions.

SASCI is supportive of a return to the US-based CPT codes, unadulterated and untainted from local negotiations. SASCI also submits that addressing the coding matter, will address many of the conflicts in the sector. One of these issues is where codes have become a way for schemes to recover monies, and to make targets set for such recoveries.

Concerns as to inappropriate servicing (under-, over-, or incorrect servicing) is therefore a professional matter and can be addressed through the formalization of peer review processes. The same would go for outcomes. This also puts the responsibility for professional conduct on the individual and their profession.

2.5. Limitations on effectively participation in negotiation processes

Professional societies are severely constrained in how it can participate in activities that will provide funders with better value for money. In any collective bargaining system, whether a national system or in bi-lateral negotiations with funders, exemption from the Competition Act would be required.

Although they can engage on issues such as clinical matters (e.g. treatment protocols), outcomes measurements and peer review, recent competition law cases against other specialist societies on coding, has left professional grouping wary of engaging even on this matter.

SASCI whole-heartedly supports a system whereby professional groupings would be able to negotiate value-based contracts with funders, on behalf of its members, with the required variability to accommodate for regional- and population differences, outcomes, experience and the likes.

For the above to happen, however, an exemption from the Competition Act is required. SASCI believes that such an exemption will serve the interest of the public at large, and give effect to the right of access to healthcare. It will allow SASCI to collect information on fees, pricing, volume and costs, and add that to data permissible under the current constraints, on outcomes, utilization and evidence-based medicine. SASCI also supports the notion of regional responsiveness.

SASCI also believes that, as part of the exemption from the Act, it is imperative that, during negotiations, **information that is currently only in the possession of the funder** (e.g. on hospitalization rates linked to cardiology), or associated costs (e.g. in cath lab fees, pathology, etc.) **must be disclosed**, to address the information asymmetry being experienced by the profession. In the absence of this data it is impossible to even currently (without exemption) negotiate around patient outcomes.

SASCI would also support a tariff benchmark system (which could be achieved through the National Health Act's RPL provisions in section 90). However, the **cost-effectiveness** of such a system, given the complexities around involving all healthcare professionals, all facilities and the likes, and the impact the system has on suppliers (whose products, or the use and reimbursement of (part) thereof are linked to billing codes), is in question together with the costs of practice costs studies, the disputes relating to data verification, the creation of data standards, etc. may not be worth anything, given the problems with utilization and other issues, such as supplier-induced demand. Benchmark- or even set or regulated (fixed) tariffs may simply not yield the necessary results in terms of value for money, and address the concerns raised by many stakeholders. To then add this to bi-lateral negotiations and the costs thereof may simply be too much for small societies to bear.

2.6. Designated service providers and networks

Where there is a shortage of professionals, such as is the case in cardiology, and given the burden of disease, it makes absolutely no sense to have exclusive agreements. The argument is put forward that one has to do so to reward those who are willing to participate,

as an incentive. However, where skills are as scarce as in cardiology, there is no rationale to exclude any provider, as the only impact is to limit access to healthcare.

SASCI supports a rights-based approach to DSPs and networks, namely that where there is a benefit awarded, all beneficiaries should be able to claim up to the level of that benefit (as giving effect to their right of access o healthcare), and such patients should not be penalized because their provider is not a DSP or a network-doctor.

The HPCSA rules, as contained in its Business Practices Policy, in relation to this is also illustrative – it requires of all providers who comply, to be able to enter a DSP or network. If contracts move away from being based on price alone, and linked to value, volume and outcomes – there is no reason why a scheme should limit its network as all patients would be able to access care under the same conditions, and at the same price.

3. CONCLUSION

SASCI has been participating in the HMI processes, and is willing to continue to engage the panel on the matters it raises in this submission. SASCI's members are in a unique position, as it represents a small professional grouping, taking responsibility for two of the ten top drivers of mortality in South Africa. This unique position (in contrast to larger specialist groups), should make clear how important a nuanced approach to this matter should be.

SASCI can be contacted at:

George Nel

SASCI Executive

083 458 5954

sasci@sasci.co.za