BD

South African Society of Anaesthesiologists

(SASA)

SUBMISSION BY THE PRIVATE PRACTICE BUSINESS UNIT OF SASA ON DEMARCATION LEGISLATION

23 APRIL 2012

1. WHO SASA IS AND ITS RELEVANCE IN A TRANSITIONING HEALTHCARE SECTOR

SASA welcomes the opportunity to comment on the National Health Act Amendment Bill, as a key preparatory step for a better healthcare system.

SASA is the South African Society of Anaesthesiologists, a professional association dedicated to the furtherance of the discipline of anaesthesia at both an academic and a clinical level and is devoted to the welfare of its members. SASA provides members with many services including free access to the official Journal of the society, numerous CPD activities, support and advice from experts, the production of practice guidelines as well as guidance and assistance over issues such as ethical billing practice, generic substitution and informed consent for anaesthesia.

SASA comprises five business units, which are all relevant to various aspects of the envisaged NHI and the reforms leading up to it, viz.:

Unit	*Scope*	*Relevance*
Education	Medical schools; awards endorsed by the Society, guidelines & standards for anaesthesiological practice;[1] CPD (Continuing Professional Development); society publications, such as the South African Journal of Anaesthesia and Analgesia	OHSC – norms & standards; Clinical Governance ("Evidence-Based Medicine" and related to the National Coordinating Centre for Clinical Excellence).
Regulation	SASA Constitution; Peer Review; Practice guidelines Congress & AGM; regulatory bodies (HPCSA, etc.).	OHSC ombud; scope of practice, ethical behavior; quality of care
Public sector	Labour relations; OSD; Registrars	HRH Strategy; OSD; health facility management
Private Practice	Private practice matters; coding; Billing guidelines; medical schemes; contracting	Reimbursement levels; DRGs, co-payments; coding
Special interest groups	RAPSA (Regional Anaesthesia and Pain Society of SA); PACSA (Paediatric Anaesthesia); SOSPOSA (Society of Sedationist Practitioners of SA) which include non-anaesthetists with a special interest in the utilization of and training in sedation techniques; Cardiothoracic Anaesthesia Society of South Africa (CASSA), which promote the science and practice of cardiac and thoracic anaesthesia and formally develop echocardiography training for anaesthesiologists	All of these Special Interest Groups would have a key role to play in the delivery of services which would be subject to the OHSC, but also subject to the HPCSA's rules on scope of practice and specialization and sub-specialities.

[1] Current Guidelines include **Procedural sedation guidelines:** SASA Guidelines for Procedural Sedation and Analgesia procedures in Adults 2010; SASA Guidelines for Procedural Sedation and Analgesia procedures in Children 2010; **Pain Guidelines:** SASA Acute pain guidelines 2009; **Airway guidelines:** SASA Airway management resources in operating theatres 2007; **Practice guidelines:** SASA Practice guidelines 2006; SASA Scope of Practice in Anaesthesia 2002.

SASA currently has a membership comprising of members in the following categories:

SASA membership	
Private	**814**
Full time public	65
Full time limited private practice	**138**
Honorary life members (some retired)	111
Trainees	294
Associates (non-specialists)	112
TOTAL MEMBERSHIP	**1534**

SASA is the largest specialist grouping in South Africa. It is, however, also a vulnerable group of specialists, identified as such by the HPCSA in its May 2011 Bulletin and the HRH Strategy 2011. The training of anaesthesiologists also takes a long time (13 years as a minimum – from starting out one's medical studies). As a much sought after skill, competition for anaesthesiologists is global, i.e. the South African health sector competes with international markets for its crop of anaesthesiologists.

2. SASA'S CONTRIBUTION TO- AND INVOLVEMENT IN THE SA HEALTH SECTOR

Members of SASA play key roles in healthcare delivery, from primary care level to the high technology settings in central hospitals. SASA plays an active role in education. It also ensures that it is active in giving guidance to its members (as can be seen from the Guidelines it issues), including peer review. SASA has, for example, proposed a simplified coding structure to prevent code proliferation and to simplify and clarify the basis for its billing. As such, it is contributing to ensure that health services costs are kept in check.

SASA has been engaged by the Department of Health on many of the NHI-related reforms, but believes that these interactions could be enhanced. SASA was, for example, unaware of the developments in relation to the demarcation draft legislation and regrets the fact that the profession has not been engaged on this important development. It remains open to discuss its experiences and positions on gap- and health insurance cover with the National Treasury.

As regards private practice matters, SASA made the decision to not take part in the RPL court case, as it believes that differences have to be addressed through active engagement and dialogue from all parties concerned. This fact is critical in light of the decision to scrap all health cover and gap cover not falling within the category of "medical scheme" cover.

3. COMMENTS ON THE BACKGROUND TO, AND JUSTIFICATION FOR THE DEMARCATION LEGISLATION

One of the main reasons for the draft legislation is said to be the prevention of "harm to the medical schemes environment" in that non-medical scheme insurance products "attract younger and generally healthy members out of medical schemes". No substantiation or data is provided for this statement. Indeed, it appears that since the advent of the medical schemes legislation in 2000, the

age profile of medical schemes have remained largely unchanged, if one looks at the CMS Annual Reports being issued. There has always been a lower rate of medical scheme cover for the so-called "young and healthy" age group (roughly age 25 – 35). To attribute this to the existence of health insurance products without any research backing up this statement appears irrational.

It is also stated that "if left unchecked [it] could result in increasing costs for the older and less healthy who remain dependent on medical schemes for their cover. Pooling healthier and sicker individuals facilitates a form of cross-subsidisation whereby sicker people do not pay contributions according to their health status; this improves the affordability of medical schemes." Whilst SASA agrees with the statement that cross-subsidiation is necessary, the achievement of this by means of the proposed draft regulations is doubtful. If this is the objective, why not MANDATE (i.e. compel) medical scheme cover for certain groups of employees as was the previous, but never implemented policy proposal?

To force medical scheme membership on the basis of closing other avenues appears irrational, and unlikely to achieve the desired objective. The stated un-affordability of schemes as much (if not more) relates to (a) the legislative framework of medical schemes (and not of other insurance products) that sets requirements relating to conditions and funding; (b) the non-implementation of the Risk Equalisation Fund (REF), to ensure that schemes with older and sicker members are able to pool their risk with schemes facing a better risk profile and (c) the unregulated role of intermediaries in the medical schemes environment, amongst others.

SASA believes that outlawing health insurance products would NOT better the affordability of medical scheme cover. If there is empirical evidence of this, such evidence should form part of the disclosures required for discussion and comment, prior to the finalisation of the draft regulations.

The "FAQ" document released with the draft legislation further states that the public is often unaware of the differences and by implication the limitations, of health insurance products. But surely it would be irrational to ban the one, if this is the true reason? A rational (and hence constitutional) approach would rather be to ensure that the public is made aware of the limitations inherent in both. Refer our discussion below on the limitations to medical scheme cover.

It appears that the National Treasury has misdiagnosed the problem, and is now prescribing the wrong medicine for this misdiagnosed condition.

4. SASA'S VIEWS ON GAP COVER AND SIMILAR INSURANCE INSTRUMENTS

4.1. "Demarcation"?

The term "demarcation" is misleading, as the drafts will actually lead to a ban on health insurance products that do not fall within a narrow range of products (HIV, frail care and emergency evacuations and travel cover). A true set of demarcation regulations would have separated (demarcated) medical scheme cover (which is a form of ***social*** health insurance, where no health risk-rating takes place and where the person can access certain levels of healthcare irrespective of their plan option and contributions) from health insurance (which is a form of ***insurance*** in the ordinary sense, where risk-rating, chosen plan, etc. determines the level of insurance received). Although both insures against the realization of the risk of ill health, the underlying legal and insurance principles are markedly different. To state that these two types of cover are "similar", and that in order to demarcate the one has to be outlawed to a large extent, would be based on a false premise.

SASA would support a mechanism that ensures clarity in delineation for both the social health insurance and the (individual) insurance market. It does not support a model where the one should give way in favour of the other. The proposed model of "demarcation" does not adequately consider the complementary nature of these two types of insurance, nor does it recognize that individual health insurance can provide access to healthcare for persons who cannot afford medical scheme cover.

4.2. The necessity of gap cover for professional services

It is common cause amongst practitioners that the levels of remuneration offered for professional services have not kept pace with inflation, the cost of living and the levels of training and experience of, in our case, anaesthesiologists. This much was borne out during the challenges experienced in relation to the National Health Reference Price List (NHRPL) and the subsequent decision of the High Court. This decision confirmed that the system, as implemented, did not recognize the data and information relating to remuneration of healthcare professionals, as placed before the National Department of Health. The same holds true for other professionals, and the costs of hospitalization (ward and theatre fees, as well as emergency services).

It is for this very reason that gap cover is necessitated in the provision of cover for the cost of professional health services.

4.3. The necessity of health cover over and above medical scheme cover

It appears that there is a perception that medical scheme cover is "complete". Medical schemes DO NOT cover all health conditions, neither do they necessarily cover all conditions in FULL. Also this matter is the subject of a court case (before the North Gauteng High Court currently being the subject of an appeal application) – in this case the Board of Healthcare Funders, representing medical schemes, are making it plain that they cannot fund the conditions prescribed by law to be funded "in full", and wishes to limit such funding obligation to levels set by them in their scheme rules. And in doing so, they are indeed blurring the "insurance" versus "social security" line.

By way of example:

- Medical schemes only have to cover so-called "treatable cancers" as part of the prescribed minimum benefits (PMBs – listed in Annexure A to the Act), i.e. cancers that have not spread to other parts of the body. Patients with cancers that do not fall within the PMB definition would rely on dreaded disease and other insurance products to ensure that they can access treatment.
- Medical schemes do not cover all joint replacements. Whereas fracture of the hip is a condition that must be covered by means of a reduction or a hip replacement, shoulder fractures (that may occur as easily in older persons as a hip fracture), are not a PMB condition.
- For the most part, medical schemes do not cover primary care (apart from the conditions listed in the Chronic Disease List, such as hypertension and diabetes) as it is not part of the PMBs.

It is for these reasons that many people choose to also have insurance policies that cover dreaded diseases, provides gaps in cover provided by schemes and in-hospital cover. Many lower-income people prioritise primary care cover over the secondary and tertiary cover offered by medical schemes, and as such may belong to only health insurance cover (sometimes for premiums below R500 – i.e. premiums far below the lowest offered by medical schemes). No other alternative exists for these people, other than the public health care system, which is currently struggling to cope with the existing burden of disease.

Even if the scheme has to fund the PMBs, limitations are placed on the extent of the cover. In such cases, gap cover and/or in-hospital and/or health insurance products assists patients tremendously. More and more patients are experiencing that even where a condition is a PMB, the scheme, or even the regulator (the Council of Medical Schemes) may make findings that the required treatment is not so-called "cost-effective" or "affordable" even in cases where such treatment is *the only option available* to such a patient for his/her condition. Prohibiting health insurance to cover such gaps not only limits a person's access to healthcare, it absolutely excludes access.

As the institutional funders of healthcare (such as the medical schemes) do not fund to the level of the value of the services rendered, gap cover is essential to ensure that access to healthcare is achieved.

5. CONCLUSION AND PROPOSAL

SASA understands why it is hypothesized that if the avenue of health insurance outside medical scheme covers is closed, people would migrate to medical schemes. SASA however believes that this hypothesis will not bear fruit in reality, as the purposes for which people buy medical scheme cover are markedly different to the reason why people would, for example, buy health cover for in-hospital, top-up cover and gap cover. Secondly, one can buy certain health insurance products for far less than the lowest premium available in the medical scheme sector. Furthermore, unless some scientific analysis underpins this, the proposed banning of the bulk of health insurance products might have disastrous implications on the health of the nation, and access to healthcare. We also believe that the constitutionality of this prohibition should be thoroughly tested, as such a limitation might be unreasonable.

SASA strongly recommends that the true demarcation of medical scheme cover from health insurance be undertaken, so that the public is not misled as to the nature of either. This may also mean tightening the nature and scope of health insurance offerings, but it does not support the outlawing of cover for the health care component of such a health insurance product.