Health Market Inquiry
Summaries of Public Hearings

HMI talks PMBs, price, regulation

23 FEBRUARY 2016

The Health Market Inquiry heard today (23 February 2016) from health care professionals in the ongoing public hearings held by the Inquiry's esteemed Panel headed by former Chief Justice Sandile Ngcobo.

Dr King, a cardiologist at Sunninghill Hospital, started the day discussing prescribed minimum benefits, particularly in relation to medicines. Dr King said that the formularies for medicines set by each medical scheme disrupt the physician's ability to the do the best for their patients and suggested that this practice compromises the quality of care for patients. Dr King told the panel about the way he manages his practice to bring down hospitalisation rates of patients, which ultimately saves the schemes money and is in the best interests of the patient. However, he indicated that the schemes and their administrators are more interested in short terms savings than long term savings or long term health benefits of the patients.

Dr King was concerned that the incentives of the medical staff sitting on the schemes' clinical committees, and who made decisions on the clinical care of patients, were skewed to save money for schemes but were not necessarily in line with the best interests of patients.

In answer to questions from the Panel about the possible use of an independent reference group to address clinical differences between schemes and practitioners, Dr King agreed but said that such a group would have to involve a large number of practitioners, whose tasks would include the drafting of guidelines that could be used to adjudicate such differences. Such capacity is limited in South Africa.

The Panel questioned Dr King about the levels of trust between health practitioners and medical schemes has previously been raised in these public hearings and also came up in the presentation by the Occupational Therapy Association of South Africa (OTASA). The chair of the Panel, former Chief Justice Ngcobo, said that he is troubled by what appears to be the diminishing faith in the HPCSA, and asked OTASA directly how that faith can be restored. OTASA said that the HPCSA needs to be more responsive to the needs of the profession and provide support and guidance to practitioners.

The Pharmaceutical Society of South Africa told the Panel about the highly regulated nature of the pharmacist profession. There are approximately 12,500 pharmacists in South Africa, all of whom are bound by provisions of the Pharmacy Act, the Medicines and Related Substances Act, the Medical Schemes Act and others. The Society argued that the rules of medical schemes affect the income of pharmacists, which on the whole is very limited.

The Pharmaceutical Society of South Africa (PSSA) argued that because dispensing fees and medicine prices are regulated by law, it was an unnecessary restriction on the profession to have negotiated designated service providers (DSPs). These arrangements simply cut out

those pharmacists who are not DSPs but who, presumably, would provide the service at the same cost to the scheme. It was argued that this mostly affects smaller pharmacies. However, the Panel in a later discussion with the Independent Community Pharmacy Association suggested that DSPs are not just about the dispensing fee alone but includes a range of contractual obligations between the health service provider and the schemes.

Just like the Southern African HIV Clinicians Society (SAHIVSOC) did in their presentation on 17 February, the Pharmaceutical Society complained about the use of courier pharmacies by schemes as a method of delivering medicines directly to members. The Society addressed the actual service that goes along with the delivery of medicines, including counselling, discussion about side-effects and correct dosages etc. This value added service that goes along with pharmacy services, is missing when couriers simply deliver medicines. The SAHIVSOC complained in particular that schemes will unilaterally change a patient's dosage without consultation with the prescribing doctor, which has an impact on clinical outcomes.

The Occupational Therapy Association of South Africa (OTASA) stated that they received many calls from occupational therapists who were unsure about how to charge for their services, which indicates the need for a benchmarking system of tariffs, associated with procedural codes. OTASA said that even though they have confidence in their colleagues in the board of the HPCSA, there are operational challenges, possibly relating to resources, and the HPCSA had not adapted to the growth in numbers of occupation therapists in South Africa. The HPCSA was also delaying the finalisation of a revised scope of practice drafted by the occupational therapists, which is important when it comes to coding and reimbursement of the therapists for their services.

On Wednesday, 24 February 2016, the hearings will commence with the South African Medical Association and the South African Private Practitioners Forum.

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Practitioners bemoan fee structures

25 FEBRUARY 2016

On 24 February 2016 the Health Market Inquiry heard presentations from the South African Medical Association (SAMA), the South African Society of Anaesthesiologists (SASA) and the South African Optometric Association (SAOA).

According to SAMA, one of its main functions is to administer and publish procedural codes which are used throughout the medical field. In a broad-ranging discussion with the Panel, SAMA admitted that its coding system was imperfect in that it is based on the US system which considers incomparable factors. Nonetheless the organisation had encountered regulatory impediments in its objective to develop a South African coding system. SAMA emphasised that there is a regulatory gap in setting prices for medical services and that the regulators had not engaged the organisation effectively in a dialogue about fees.

SAMA reiterated concerns raised by other practitioner organisations that medical schemes are forcing doctors to be 'price takers', who charge patients what schemes are willing to pay. This results in co-payments because what schemes are willing to pay does not reflect the value of the service provided. A connected concern for SAMA is the preferred provider network, which restrains the fee practitioners can charge and consequently doctors are providing the health care services as determined by the schemes, and not necessarily the best care for their patients. The Panel suggested that one of the positive factors of the network may be that its members can charge higher rates for their services. However, SAMA disagreed asserting that the fee may sometimes work out to be less.

SAMA argued that a system which requires patients pay to upfront for healthcare and are later refunded by the schemes, creates a barrier to access as some people cannot afford to pay fees upfront.

SAMA submitted that the certificate of need is an insufficient means to address the issue of the concentration of practitioners in urban centres because there is a scarcity of skills. In other words, they cannot 'move people who do not exist'. The solution should be focused on creating a sustainable and attractive health profession and sector. In response to a question from the Panel on how skills shortages were compounded by the issue of patients seeing specialists for primary health care needs, SAMA recognised that a tariff for primary health conditions, applicable to both GPs and specialists, may be the route to take.

Additionally, SAMA was asked about PMB training for its members. SAMA refuted the claim that doctors were not informing patients of relevant PMB conditions. SAMA stated that the large number of complaints about PMBs lodged with the Council for Medical Schemes was indicative of the fact that problem did not lie solely with the practitioners and that schemes should not be 'let off the hook'. Even though the issue of PMBs needs to be addressed by both the profession and funders, the population needs to be aware of their entitlements and as such, SAMA offers courses across the country to educate people about their entitlements in the private health system. SAMA said its members participated in continuous professional development focusing on ethical responsibilities, and it frown upon practitioners who do not inform patients about the care that they are receiving, what their options for care are and the cost implications.

The South African Society of Anaesthesiologists (SASA) criticised the HPCSA saying the regulator is 'at best, dysfunctional' and that the profession needs a better structure that can provide adequate guidance to the profession. SASA advocated for a benchmark fee, arguing that it would help set a fair tariff because there is too much confusion in the sector about fees.

SASA noted that health services are also regulated by the Consumer Protection Act which provides that practitioners should provide patients with information relating to the procedure and the cost of services. SASA echoed the sentiments of other practitioner groups, saying that the focus of medical services had shifted to non-medical considerations because of the funders. The Panel referred SASA to the OECD study presented last week at the Inquiry, which states that while there is a high admission rate, the length of hospital stay was comparatively short in South Africa. SASA accepted that funding affected the time patients spent in hospital.

SASA also complained that PMB requests for funding of conditions were routinely processed only 120 days later and that this forced patients to pay out of pocket and essentially lose out on a benefit for which they had paid.

The South African Optometric Association (SAOA) suggested that certain DSP arrangements amounted to an abuse of dominance.

SAOA was asked about its view on the employment of specialists by hospitals, which is currently not allowed by the rules of the HPCSA. SAOA was concerned about the employment of doctors specifically because the three large hospital groups in particular are publicly listed companies and have obligations to their shareholders. Whereas doctors have important ethical obligations towards their patients.

IsoLeso Optics Ltd took issue with the multiplicity of coding structures and the limited PMB coverage for optical needs.

On 25 February 2016, the inquiry continues with the HPCSA, regulator of the health profession. There has been much criticism of the HPCSA during the course of the hearings so

far and it will be interesting to see how the discussion between the Panel and the regulator unfold. Follow us on twitter @SECTION27news for updates.

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HMI panel grills HPCSA

25 FEBRUARY 2016

Health Professions Council of South Africa

The last day of the second week of public hearings for the Health Market Inquiry began with submissions and extensive questioning of the Health Professions Council of South Africa (HPCSA).

The HPCSA, which comprises over 30 health professions and 12 Professional Boards, began the day by detailing its scope and purpose. Though these Professional Boards generally enjoy autonomy with regard to the regulation of their professions, the Health Professions Act delegates the HPCSA with general overarching powers and obligations to "assist in the promotion of the health of the South African population" and "serve and protect the public in matters involving the rendering of health services by health professionals". This was affirmed in the HPCSA's submission in which the President noted "We must guide professions. We exist for the public: not the other way around."

The HPCSA delegation was asked by Chief Justice Ngcobo if there was a reason that they had failed to make written submissions to the Panel to which the HPCSA responded that this was due to a lack of time. This is particularly disappointing given that the HCPSA is mandated to "be transparent and accountable to the public in achieving its objectives" . The HPCSA is an important stakeholder in the health system in South Africa. Given the failure to supply a written submission, the HPCSA was put through intensive questioning by all five panellists of the Health Inquiry. The starting point of the HPCSA's submission was an acknowledgment of how the inequitable healthcare system complicates its mandate. Because the HPCSA has a mandate in both the public and private sectors it matters, it submitted, "that in the private sector there are more health professionals than in the whole public sector".

Ethical Tariffs

The most significant issue tackled by the HPCSA was the regulatory gap which exists with regard to ethical tariffs in South Africa. These ethical tariffs would allow patients to know when they are being overcharged for certain procedure and consultations and have recourse to the HPCSA if they had complaints about overcharging. Surveys show that many people believe that they are currently being overcharged.

The HPCSA decried the fact that as a result of a combination of a Competition Commission ruling (which found collusion in the setting of prices) and a High Court judgment (which struck down an attempt to regulate prices on procedural grounds) that "health has been commoditised [so] we cannot do our job and treat health as a right". The Panel seemed sceptical of the HPCSA's reliance on this excuse questioning "why I it taking so long for the HPCSA to review the ethical tariffs". The process, in regard of which SECTION27 made detailed submissions in 2013, began as early as 2012. The HPCSA concluded that "we have heard that Department of Health wants to wait until the completion of the Health Market Inquiry process to 'do it properly'". Whatever the reasons for the delay, patients are currently left without any guidance about whether they are being overcharged by health professionals despite the HPCSA having a statutory duty to fill this void. When pushed, the President of the HPCSA suggested that patients themselves simply ask about prices "who of us goes to a restaurant and eats first and asks about the price after?", he asked. This is a surprising submission in light of the continuous thread through the first two week of submissions in which health professionals themselves have frequently found that patients know little about their rights and how little bargaining power they have when it comes to the provision of healthcare.

The Panel also incisively questioned whether healthcare providers and medical schemes were merely taking advantage of the absence of a tariff structure to make more money "I wonder what degree to which the Commission's ruling has been used as an excuse by private companies?" Professor Sharon Fonn asked.

The state of the HPCSA as a regulator

The Minister of Health recently convened a Ministerial Task Team (MTT) to conduct an investigation into the HPCSA due to an increased number of complaints about the HPCSA's dysfunctionality. Recommendations from the MTT confirm that the HPCSA "is in a state of multisystem organisational dysfunction" and reveals "irregularities" and "maladministration". The Chief Justice inquired as to the "status" of the Department's report which was concluded in 2015. Contrary to its statements in the media earlier this year, the HPCSA confirmed that it had been reporting to the Department on its progress in implementing the MTT's recommendations and that "all the issues are being looked into". Most optimistically, the HPCSA reports that it is "doing a total review about the way it deals with complaints" with the possible assistance of a retired judge. Another question that was put to the HPCSA was about whether the HPCSA had "taken initiative" to "create synergies" between health professionals in the private and public sectors to alleviate inequality. Despite previously speaking strongly to the inequity between these two sectors, the HPCSA confirmed that it had not taken any steps to eliminate it. In response to a question posed by the Panel, the HPCSA also admitted that it "had not done enough" and that "we need to become more visible in the protection of health professionals".

Relationship with the Council for Medical Schemes

Medical schemes compliance with the law has been in the spotlight throughout the Inquiry hearings thus far. Medical schemes are regulated by the Medical Schemes Act which is governed by the Council for Medical Schemes (CMS). It was not surprising then that the Panel questioned the HPCSA about its relationship with the CMS and Medical Schemes. The President of the HPCSA emphatically condemned the conduct of medical schemes saying that "the 'new tyrant on the block' called medical aids causes [issues] for practitioners" by "interfere[ing] with professional management of patients". Worryingly, the HPCSA also indicated that it had tried to contact the CMS but that it had received "no response or cooperation."

Other issues

When questioned about the common challenge faced by foreign-qualified doctors in acquiring registration in South Africa, the HPCSA responded emphatically that the problem was with "non-complying applications" despite clear instructions and requirements on its website about applying for registration. The evidence leader of the Health Inquiry Panel suggested in response that given the need for doctors in South Africa the process of registration of foreign doctors should be "expedited".

The HPCSA also made general submissions on the "commodification" of health services which included submissions on advertising, technology and and the hiring of health professionals by private hospitals. Their position was most emphatic with regard to the controversial debate about the employment of health professionals "if we allow health professionals to be employed by private entities then it will turn a crisis into a disaster". Overall, the HPCSA opposed the increased trend of corporatisation of health services, concluding "the stock market cannot determine how you treat your patients"

The South African Medical Device Industry Association

The South African Medical Device Industry Association (SAMED) cited a number of challenges faced by the medical device sector. Chief amongst them was exchange rate fluctuations which impact profit margins as 75% of medical devices are imported and only 25% are manufactured in South Africa. SAMED pressed home the point that manufacturing medical in South Africa is extremely expensive, as is importing them. Some suppliers have had to withdraw services from the public sector due to non-payment and have indeed gone out of business because of the fluctuations in cost.

The Panel probed SAMED about reports of corrupt behaviour amongst their members, which included collusion with hospitals in relation to rebates for devices and incorrect invoicing. SAMED assured the Panel that it had acted to root out such behaviour amongst its members, including by implementing a code of conduct in relation to rebates and by asking member to be transparent in their invoicing.

SAMED appealed to the Panel to consider recommending that medical devices be included in the list of Prescribed Minimum Benefits, which would allow doctors to broaden the scope of treatment available to patients.

SAMED also indicated that it wanted regulations in place to ensure safe, reliable devices regardless of price. The association said that it had made submissions to the Department of Health in this regard but await finalisation of a draft bill in Parliament. It was unclear whether this was related to the legislation establishing the South African Health Products Regulatory Authority, which will have responsibility for the safety, efficacy and quality of medical devices. The law has been passed by Parliament and the Authority will begin work in April 2017.

Dental Practitioners Association

The last group to make oral submissions to the Inquiry today was the Dental Practitioners Association (DPA), which reiterated the challenges raised by other professional organisations, including the sometimes coercive relationship between practitioners and funders. The DPA complained that schemes routinely set low tariffs for dental services, which are not appropriate and result in unavoidable co-payments.

The DPA also discussed information asymmetry, saying that the failure by funders to inform users of their benefits and the use of language that cannot be easily understood by users is deliberate.

The DPA raised concerns about the profit-making of medical scheme administrators. According to the DPA, the expenditure of administrative costs outsourced to third party administrators was 40% higher than the expenditure in self-administered schemes, suggesting that self-administration facilitates cost saving.

The DPA also raised concerns about preferred provider networks, asserting that the protocols and rules imposed on providers in those networks influence how practitioners treat patients. They suggested that the further development of such networks will contribute to market concentration and make it hard for new players to enter the market.

The DPA criticised the government for allowing two systems of healthcare to develop in South Africa arguing that a failure of management has resulted in resources being tilted in favour of the private healthcare sector. Adding that the multiplicity of regulators creates a disconnect in regulation.

Concluding Comments: Some observations about the HMI public hearings this far

At the conclusion of the 2nd week of hearings there are some observable patterns emerging about the functioning of the private healthcare sector. Different stakeholders have presented their views about what is wrong within the private health sector, some have offered concrete

suggestion while others have shifted responsibility onto others. The Panel has impressed with its incisive questioning, its broad knowledge of the healthcare sector and its seemingly encyclopaedic knowledge of the nearly 70 extensive written submissions. The Health Inquiry is shaping up to have the potential to ensure the better protection of rights of patients in the private healthcare system. The public should continue to engage with and make submissions to the Health Inquiry to ensure that patient's voices and rights remain at the centre of the entire process.

Panel deepens probe into Healthcare

2 MARCH 2016

The Market Inquiry into the Private Healthcare Sector began its third week of public hearings with presentations from the Board of Healthcare Funders (BHF), the Government Employees Medical Scheme (GEMS) and Bestmed, amongst others. The day's hearings were punctuated with surprising and sometimes contradictory statements. Here is a summary of presentation by the BHF, GEMS and Bestmed.

Board of Healthcare Funders

The Board Healthcare Funders (BHF) explained to the Panel that it "represents over 70% of Medical Schemes" in addition to a significant proportion of medical scheme administrators and managed care programmes. Medical schemes (commonly referred to as medical aids) are not-for-profit entities according to the Medical Schemes Act. This is not the case for medical scheme administrators.

What does the BHF do?

Panel member Prof Sharon Fonn questioned the BHF on its mandate and purpose, asking "What do the BHF do? Who are you? Do you represent schemes? Do you represent their members?". This question seemed to be one shared by other panel members. The panel also asked BHF how it could claim to represent Medical Schemes "who then contradict what BHF said in their submissions"? The Panel also asked for clarification about the functions and activities undertaken by the BHF. Here are some examples:

Panel: "How much time does BHF dedicate to enhancing access to health services?"

BHF representative: "Having joined this organisation in 2005 I can say 'not much'

Panel: “What measures has BHF introduced to provide members with information?”

BHF representative: “We have not done enough. We need to do more.”

BHF had previously initiated litigation seeking clarity on the meaning of the provisions concerning Prescribed Minimum Benefits in the Medical Schemes Act. The BHF suggested that this litigation was done with the encouragement of the Department of Health, which had also sought clarity on the meaning of “pay in full” in terms of the PMB regulations. This action, coupled with inaction in other areas, seemed to raise some further interest from the Panel. A panel member questioned whether the BHF “doesn’t consolidate power” given the fact that “many submissions allege medical schemes & administrators have way too much power” as it is. It will be interesting to see if the Panel further investigates the impact of the BHF on the markets in which its members operate, including whether its existence contributes to anti-competitive practices or violations of patients’ rights to health

The BHF’s understanding of the role of medical schemes

The BHF presented a confusing and at times contradictory understanding of the purpose of medical schemes. Though the Medical Schemes Act does not set out an explicit purpose for the Act and Medical Schemes, SECTION27 in its submissions argued that in terms of constitutional law, the purpose of both the Act and medical schemes must be interpreted in light of the constitutional right to health. Medical schemes, as not-for-profit entities clearly exist to protect the interest of their members which ultimately includes, primarily, their access to quality healthcare services.

Though beginning its submission by acknowledging that “we know that with healthcare the SA Constitution is primary”, the BHF then immediately proceeded to describe medical schemes as a “financing vehicle for health services” and emphasising that “the business of medical schemes is not health.” This submission follows on a worrying trend thus far from some private sector market participants of paying lip service to the constitutional right to health and then denying any responsibility to ensure that it is made a reality.

To confuse matters further, later on in its presentation, the BHF complained that a problem with the private healthcare system is that it is “finance-centric not health-centric” and that “financers” (the BHF’s own members) “are not promoting health access”.

The relationship between medical schemes and medical scheme administrators

Given the fact that the BHF has some members who are medical schemes, on the one hand, and other members who are medical scheme administrations on the other, the Panel asked BHF representatives to explain “how can it be efficient for there to be two players: medical schemes in medical schemes administrators?” This question was followed up by the Chief Justice who interjected to ask “is there a potential conflict of interest here?” and if so “how does the BHF deal with it?

Interestingly, the BHF responded by acknowledging the potential for a conflict of interest without explaining how it is handled by the BHF and its members. It said that the source of the conflict was based on a question about whether incentives of entities – schemes and administrators – are related to healthcare outcomes or cost savings. This question has clear relevance to the discussion about the crucial role of medical schemes in protecting patients' rights.

Specific issues raised by the BHF

BHF raised several issues in their submissions relating to the Prescribed Minimum Benefits. In this regard, the BHF, as many others, highlighted the concern that the PMBs "have not been reviewed since 1997". Prompted by questioning, the BHF also submitted that prior to the passing of regulations and legislation with regard to PMBs, "costing was not adequately done" and furthermore there is "no capacity at all to monitor implementation".

Broadly, the BHF emphasised with reference to the WHO report presented in the Pretoria hearings that "the lions share of what is collected [from patients] goes to private hospitals and specialists". The BHF therefore firmly recommended "price regulation" for hospitals and specialists stating that "detailed regulation" would lead to "downward pressure on costs". The BHF also emphasised the lack of bargaining power that medical schemes have in terms of the Council for Medical Schemes' meaning of "pay in full" in terms of the PMB regulations. In BHF's view, paying in full on invoice – a legal requirement – is "reckless spending of Trustees money". This is the opposite of the submissions made by health care providers, who have said at the public hearings that the schemes hold the power and that healthcare providers are "price takers".

Bestmed

Following BHF's submission, the Panel heard from Bestmed Medical Scheme. Bestmed is an open and self administered scheme. In their submission, they emphasised the importance of brokers for self-administered schemes saying that brokers act as marketing agents and bring new members to the scheme. Bestmed said that the reality is that open schemes compete on their ability to attract younger healthier members to fund healthcare coverage. The nature of social solidarity in schemes functions to pool the risk of the healthy and unhealthy. In their final remarks Bestmed built on this point asserting that the users' distrust of schemes can be associated to circumstances when the schemes act in the collective interest of all of its members over individual interests.

In principle, Bestmed said it was not opposed to regulation but argued that the present regulation is inappropriate, and that PMB regulation in particular is an example of the imbalance of regulation between health service providers and medical schemes. Like BHF, Bestmed argued that the obligation on schemes to pay out in full for PMB conditions should attract regulation on the pricing of medical services to curtail costs. However, Bestmed

acknowledged that the Designated Service Providers exemption envisaged in PMB regulation serves as a mechanism to mitigate what seems to be limitless liability placed on schemes.

Bestmed blames PMBs for the increase in costs and cited cases of exploitative behaviour by service providers who, for example, bill more for conditions identified as PMBs because of the requirement of full payment. Even though this conduct is not prevalent, they admitted, Bestmed affirmed that it occurred and is a possible driver of costs.

Bestmed repeatedly criticised members of medical schemes, insisting that they expect their contribution to translate to good healthcare provision and are not price sensitive. This is a curious criticism because both the panel and different stakeholders have picked up on the concerns about information asymmetries between schemes and users, advocating for openness and transparency in the system.

Government Employee Medical Scheme (GEMS)

As a restricted medical scheme, GEMS is only open to those who are employed in the public sector, and their dependants. As Panellist Mr van Gent commented, "GEMS is like a market in itself".

The Panel was very interested in the special nature of GEMS in light of its relationship with the State. GEMS serves public service employees, has its Trustees appointed by the Minister of Health, reports to state entities such as the Ministry of Health and Treasury on its operations. This prompted the Chair of the Panel to ask whether GEMS was in fact an organ of state or whether it had any additional responsibilities given its connection to the state, for example, obligations in terms of the Public Finance Management Act (PFMA). GEMS indicated that it did not have any special responsibilities, but was governed by the Medical Schemes Act like all other schemes.

GEMS indicated that the state, which includes public hospitals, was its chosen Designated Service Provider for PMB conditions. It stated that in most instances, GEMS pays for public hospital services but if a member chooses to attend a private hospital, GEMS would pay the private hospital at the GEMS scheme rate, with co-payment from the member. GEMS noted that hospital costs were not significantly higher than the GEMS rate but that if specialists were involved, the costs tended to be very high. In relation to the quality of services in the public health sector, Chief Justice Ngcobo asked what GEMS was doing to improve the quality of health care in the public sector. The GEMS representative gave no satisfactory answer simply stating that the Minister is taking steps.

The public hearings continue with the much anticipated presentation by Discovery Health on Wednesday 2 March 2016.

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HMI interrogates health insurers

2 MARCH 2016

Discovery Health Administrator

Today, 2 March 2016, Discovery Health Administrator (DHA), led by Dr Jonathan Broomberg, made its submissions to Health Inquiry. DHA is a for profit entity, unlike Discovery Health Medical Scheme (DHMS) – a non-profit entity – which will make submissions to the Panel tomorrow.

Cost-drivers in the private healthcare sector

From the outset DHA was emphatic that it was not fees for the administration of medical schemes that contributed majorly to cost increases in the private healthcare sector in South Africa, noting that "in an inflationary environment DHA admin fees are deflationary". In an attempt to explain the above-inflation increases in the costs of private healthcare, Dr Broomberg said that the primary problem is not price inflation but "utilisation" which "increases by 4.6% every year". He highlighted this, concluding "we think it is incontrovertible that high utilisation is the result of [increased costs]". He said that this was confirmed in at least five other major submissions, including those of hospital groups and Econex, an independent economic consultancy.

DHA also highlighted various issues, beyond the control of medical schemes that may also be cost drivers. One example, cited was "adverse selection", whereby "people join just as they're planning to claim more than they contribute."
Regulatory environment and PMBs

DHA suggested the Panel may have been "misled" about PMB compliance by some stakeholders. Dr Broomberg maintained that DHA is fully compliant with PMB legislation both the spirit and the letter and "makes every effort to pay in full" and is successful in doing so in the vast majority of cases. In the 9% cases in which DHA fails to pay PMBs (other than chronic illnesses) in full, the major explanations include members choosing to use non-designated service providers or not providing complete information on claims.
Overall, Dr Broomberg emphasised that most patients are extremely satisfied with the quality of services provided by DHA and DHMS. Last year, for example there were only 800 complaints to the Council for Medical Schemes about DHA out of over the 44 million claims made. He also commented that, contrary to what the Board of Healthcare Funders had submitted to the Panel, "on balance consumers of private healthcare enjoy very good quality of care".

Nevertheless, the DHA did make submissions on problems with PMBs. Coming back to their earlier submissions about over-utilization DHA submitted that incentives must be changed from the present circumstances in which "doctors [are] choosing to do more to earn more".

Dr Broomberg also suggested that sometimes, in the patients' interests, doctors currently have an incentive to diagnose them with conditions that are covered by the PMBs. This could explain "dramatic year-on-year increases in diagnosis of bipolar depression", which is one of two mental health conditions fully covered as a PMB.

Absolute level of prices

Throughout, various members of the Panel questioned DHA about the absolute level of prices in the private healthcare sector. Dr Broomberg responded said that absolute prices in South Africa are "not out of line with global standards" and were in fact "very competitive with OECD countries". Dr Broomberg noted that the WHO and OECD study presented to the Panel that concluded that South Africa was the "least affordable" private healthcare system compared to OECD countries suffered from "fatal flaws" and crucial methodological problems.

Later, when questioned about DHA's power in preventing cost increases from hospitals and specialists, Dr Broomberg conceded that the DHA has "not been successful in cutting the base that was inherited in 2005" and welcomed a relook at base prices from 2005.

Brokers and Vitality

Throughout the public hearings, the Panel has asked about the role of brokers in the medical scheme environment. DHA's submissions indicated that brokers play a crucial role in the choice of medical schemes. In addition, according to DHA, brokers advise prospective members about packages and inform members of medical schemes about their rights and the benefits in relation to medical schemes and packages. Finally, in the context of DHA, brokers may not only assist in selection of medical schemes but may also sell prospective DHA members complementary services such as those offered to DHA members by Vitality.

DHA did not mention its Vitality programme until prompted by a Panel member. DHA emphasised that it is a "completely separate business" and is "entirely voluntary" for Discovery members. The purpose of Vitality is to get young members to join the medical scheme in order to remedy the adverse selection problem.

In relation to the conduct and business practices of brokers Judge Ngcobo asked "whether DHA knows whether brokers do their jobs properly?" Dr Broomberg responded that DHA has contracts with brokers to ensure they perform the tasks that they are required to and that activities of brokers are also regulated.

Member's knowledge about schemes and their rights

The Panel raised various questions about the low knowledge of users of the private healthcare system of their rights and how the system works. In this regard, DHA said that people "tend to not focus on the detail of their schemes" until they need them to claim. This, Dr Broomberg said, was supported by a growing field of evidence in behavioral economics. This led to a

prolonged exchange with the Chief Justice who seemed unsatisfied with Dr Broomberg's answers, and pushed further asking "hopefully at some stage you will give us full explanation of who is to blame for patients not knowing?" To this Dr Broomberg responded that this is a "global problem". The Judge again interjected to specifically ask what mechanisms DHA has put in place to solve this problem.

Although he acknowledged that lack of information was still a problem, Dr Broomberg said that it was provided on phone lines, in contracts and by brokers. He listed websites, emails, letters and mobile applications as other channels for keeping members informed.

Ultimately the Judge's concern, which is of central importance to the Health Inquiry, remained. He asked if DHA and others "accept the problem" exists why do they not solve it "on the ground"? He also pushed back against the suggestion that the lack of information available to users of the private healthcare sector is a "complex issue" asking "what is complicated about a person getting sick and knowing where to go and what to do?" Dr Broomberg ultimately agreed that "it is bad for our members and bad for us if members don't understand."

Prompted by a question from the Panel about whether DHA was satisfied with the status quo in the private healthcare sector, Dr Broomberg again referred back to the issues of prices and patient knowledge. He answered "we are not happy that the products are as complex as they are". He said "that consumers are hurting … we cannot be satisfied with that" and that there are "significant improvements" that can be made "both to cost and to quality" in the private healthcare sector.

Judge Ncobo questioned DHA on quality of health care services and whether DHA shares quality data with members of schemes. Dr Broomberg explained that it did not because it would compromise the relationship with the doctors and hospitals whose cooperation they need. The Judge pressed on, "doesn't that compromise members"?

The discussion then shifted to the constitutional obligations of the private sector players, which Dr Broomberg characterised as limited to supporting the state in meeting its constitutional obligations in respect of the right to health. The Judge was not satisfied with the answer and asked whether the private sector stakeholders were not subject to the constitutional right, which is fundamental to the Constitution and is sometimes a matter of life and death. Dr Ayanda Nstaluba, also of Discovery Health, stepped in to say that section 27 of the Constitution reflects the pact entered into by all the stakeholders, and that achieving the objectives involved the state but that the private sector had a role in helping to attain the objectives of the Constitution.

MMI Holdings

MMI Holdings Limited is the consolidated company following the merger between Momentum and Metropolitan. Through its subsidiaries, MMI is involved in health

administration and the management of medical schemes. In its submission to the Panel, MMI highlighted the inequalities in income distribution and made use of the OECD and WHO comparative study to reiterate the concerns of the high price of private hospitals in South Africa.

MMI discussed its views on the risk equalisation fund, which was brought up by the other schemes, saying that the lack of risk equalisation is problematic and leads to older, sicker people being forced to discontinue membership as they become unable to afford premiums.

Again PMBs were considered as a cost driver, with MMI submitting that PMBs contributed to the increase of specialist fees, adding that the dramatic increase coincided with the decision to set aside the Reference Price List in 2010. MMI also raised the failure to review PMB regulations since their implementation in 2000, stating that the treatment algorithms no longer reflect current evidence or cost effectiveness. It further criticised the private health sector's regulatory framework arguing that it is incomplete and fragmented.

MMI agreed with Bestmed that open schemes are reliant on brokers to bring them new members and noted that smaller schemes experienced difficulty with large brokerage firms that are incentivised to work with larger schemes. MMI also suggested that players in the sector such as specialists and GP's have unequal bargaining power in the market and that this indicates the need for a well structured multilateral system for tariff determination, overseen by independent organ of state.

As with Discovery, the Chair asked MMI about information asymmetry, in particular why the system was so complex that it could not be simplified for members and what MMI was doing to address the information asymmetry. The Chair also pursued questions about whether MMI provided beneficiaries with information about the quality of health care services provided by particular providers, particularly if there were reports of poor quality. MMI had to concede that it did not and that, ordinarily, beneficiaries would be penalised if they attended a non-DSP, and would not be told that the reason that the provider was not a DSP was because of poor service. The Chair characterised this as vital information for a member to be able to make decisions about their heath care.

Unlimited Group

Unlimited Group is a financial service provider and described itself as a direct marketer of health insurance products. It has 5000 principle members. It pays out to the individual member and not health care service providers. The main concern of this stakeholder was the draft demarcation regulations applicable to the Long Term and Short Term Insurance Acts, published by National Treasury. They are currently governed by Financial Advisory and Intermediary Services (FAIS) Act, amongst others.

Unlimited addressed the concern in the industry that such health insurance products could draw young people out of medical schemes or divert them before entering a medical scheme.

The insurance products include Hospital Cash Plans (HCP), which aimed at covering any expense incurred by members in the course of hospitalisation, including non-medical items.

The draft demarcation regulations limit products to non-medical expenses and capped at R3000 per day. Unlimited suggested that because their products target people outside of medical scheme, the products are not in competition with schemes. They also noted that the exploration of initiatives to create low income medical scheme started 10 years ago, with a more recent initiative started by the Council for Medical Schemes apparently abandoned in 2015.

Unlimited went on to suggest that the draft demarcation regulations will restrict the ability of people to get cover for medical costs and contingent liabilities and would therefore constitute violations of section 27(1) of the Constitution. Unlimited further alleged that the draft demarcation regulations indirectly discriminate against low income individuals, who, without insurance products, would not be able to access private health care. In this regard, Unlimited stated that the Patient Rights Charter includes "a right to insurance". The complete provision of the Patient Rights Charter provides that patients have a right to "Knowledge of health insurance and medical aid schemes".

When asked what recommendation Unlimited wanted the Panel to make in relation to the draft demarcation regulations, Unlimited indicated that the Panel should urge Treasury to await the outcome of inquiry before finalising the regulations as the Inquiry would otherwise be moot at least in so far as health insurance products affected by the regulations was concerned. The Chief Justice challenged the notion and said it would be inappropriate for the Panel to do so but wholly appropriate for the insurers to do so or to even approach a court to seek that kind of relief. The Chief Justice then qualified the statement and said he was not giving legal advice and could in fact be wrong.

Unity Health

Unity Health markets primary health care insurance products. The starting point of the presentation was that medical schemes are exceedingly expensive and the majority of people cannot afford to belong to a scheme. Unity went on to list the "failings" of medical schemes, including the community rating, open enrolment and other social solidarity policies contained in the legal framework for schemes.

Based on the latest General Household survey, Unity suggested that black people only represent 10% of medical scheme membership and explained the number by suggesting that blacks earn less than other groups. While this seems like a giant leap, Unity went even further to suggest that mostly young black people belonged to schemes, and -as young and healthy people generally cross-subsidise the old and sick – it meant that young black people were cross-subsidising older white people. As if that were not enough, Unity stated that the social solidarity principle of community rating was unconstitutional because of the cross

subsidisation along racial lines. Panellist Dr Nkonki asked, "would you accept that blacks are not homogenous in terms of income" the Unity representative answered that they looked at averages. However, Dr Nkonki contended that even on that methodology, the statement that community rating disadvantages blacks is not true.

During question time, the Chair of the Panel challenged Unity's approach in launching a broad attack on the medical schemes in order to show the benefits of its own products.

In defending the benefits of its own products, Unity indicated that its focus was on private health insurance products for primary health care and that they were much more affordable. Other benefits included:

- Expanding private health insurance to 19 million people currently without medical aid
- Creation of 500 000 new jobs in private sector
- Reduce burden on state facilities
- greater efficiency
- increased tax revenues of approximately 3%.
- Better quality of health and overall well being with focus on preventative care
- Generally "all good for the economy"

Panellist Dr Bhengu challenged the assertion that health insurance products were 10-15% of medical scheme costs, calling the statement misleading as it compares insurance primary health cover with medical scheme full cover, including PMBs.

Unity then went on to attack the National Health Insurance plan, which it characterised as an unsustainable funding model that would lead to an economic downgrade.

Unity concluded that its products increase competition in the market, which leads to an improvement in the quality of care at cheapest possible price and which is progressive and clearly in the public interest. Lastly, Unity stated that disallowing private primary health insurance (as proposed by the draft demarcation regulations) would be unconstitutional.

Panellists Dr van Gent, Dr Bhengu and Professor Fonn challenged the concept that the health insurance products were any different from medical scheme proudcts. Dr Fonn asked what Unity does in respect of social solidarity, which was not answered directly. Her question about what happens when Unity's members get really sick, elicited the following response: "We are trying to cover something at some cost and the rest would have to go into the state. Its better than nothing."

Verirad (Pty) Ltd

Verirad are pathology and radiology risk managers.

Verirad started its submissions by responding to some of the previous submissions made by the laboratory stakholders. For example, by pointing out that none of the laboratory submissions to the Inquiry address alternative reimbursement models. The representative from Verirad suggested that the Panel specifically request these details from the pathologists or schemes that engage in such arrangements.

Similarly, there were no submissions from suppliers of pathology tests. However,again, the representative pointed to potential sources of information, including the National Health Laboratory Service and the South African Laboratory Diagnostics Association, which sells pathology tests into market, to provide the Inquiry with the prices of tests.

Verirad noted that Pathcare laboratory posted its prices per test per medical scheme on its website for a time, but the documents were subsequently removed. However, Verirad captured some of the information and learned that the same basket of tests, including the high volume tests such as urea and electrolytes, creatinine, FBC, platelets, ESR and INR were priced differently for different schemes. Verirad compared the prices and found that the tests were priced at around R200, R300, R400 and R500 for exactly the same tests across a sample of about six schemes. Further analysis showed that malaria could be tested for between R140 and R500.

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HMI puts Discovery under microscope

4 MARCH 2016

On 3 March 2016, the Health Market Inquiry first heard from Kwanele Asante-Shongwe, who is the founder of the breast cancer advocacy organisation, BreastSens. In her submission Asante-Shongwe drew attention to the wide gap between those who have the resources to access healthcare in the private sector and are in some way able to buy access to the best doctors and those who do not.

A cancer survivor, living with a heart condition herself, Asante-Shongwe is aware of the high cost of treatment and medication in the sector. She dramatically tipped out a shopping bag full of the medication essential for her survival onto the table. She maintained that access to treatment should not be predicated by how big your wallet is and implored the industry to probe their corporate responsibility and balance profit-maximisation with the exclusion of people from access to healthcare services. Asante-Shongwe advocated for the transformation of our patent laws to create a space for the manufacturing of generic drugs and procuring medicines at a more affordable rate.

Although the duty to ensure access to healthcare primarily rests with the state, Asante-Shongwe noted that it is not only the state's responsibility to make public interest considerations of cost efficacy and safety when providing healthcare services. Chief Justice Ngcobo added that the International Convention on Economic, Social and Cultural Rights is binding on member states and comments on the obligation to make healthcare accessible and affordable in both the public and private sector.

Asante-Shongwe said that a complete policy framework was needed and that as long as the framework remained inadequate millions were being denied their rights to healthcare.

DISCOVERY MEDICAL SCHEME

Discovery Health Medical Scheme (DHMS) led by Mr Milton Streak, made oral submissions the day after Dr Johnny Broomberg made submissions to the Panel on behalf of its administrator, Discovery Health (Pty) Ltd (Discovery Health).

In this round of public hearings, the Health Market Inquiry Panel is attempting to get to grips with the relationships between and amongst the stakeholders in the private health sector.

This includes the relationship between schemes and their administrators. The relationship between DHMS and Discovery Health is of particular interest to the Panel because they are part of the same group of companies and seem to be inextricably linked. However, speakers for both entities were at pains to emphasise their individuality.

DHMS is the largest open scheme in the country, with 2.7 million beneficiaries. The Board of Trustees has oversight over its operations and must act in the best interest of all the members.

DHMS contracts with Discovery Health for administration and managed care services. Very early on in the presentation, Judge Ngcobo enquired what it really means to say that a scheme belongs to members.

Mr Streak explained that members fund the pool of contributions, and for that reason the scheme is obliged to pay their claims. In other words, the pool of funds is for the benefit of all members' claims.

Governance structure

Mr Streak described a governance structure that clearly distinguishes between the business of the medical scheme and that of Discovery Health. The Trustees are elected by scheme members and appoint the CEO of the scheme. The Trustees take a decision to outsource administration and managed care services – to Discovery Health – on a three-year cycle. Mr Streak described the relationship as "vested outsourcing".

The principles of the outsourcing model governing the relationship between DHMS and Discovery Health involves:

- A focus on outcomes, not just transactions
- Outsource to experts
- Effective oversight

Panellist, Dr van Gent commented that despite his debate with Dr Broomberg about the "integrated" nature of the relationship between DHMS and Discovery Health, he still thought of the two companies as fully integrated. Dr van Gent noted that DHMS was comprised of 7 executives, 2 senior managers and 3 support staff while Discovery Health had about 3000 staff. In other words, he said, Discovery Health dwarfs DHMS, particularly in analytical power. He asked what Mr Streak thought of the balance of power between the two.

Mr Streak indicated that the Board of Trustees, and the ability of the board to appoint outside expertise, effectively balanced the power. Dr van Gent asked if DHMS could function if it did not get along with Discovery Health. One of the Trustees responded that it would be difficult if DHMS did not have the information and analysis for which they pay administration fees, but that the remedy would be to terminate the relationship on 90 days notice, if that was in the interest of the members. Dr van Gent did not seem persuaded and commented that he was trying to understand the legal independence as distinct from the reality of independence between the two. He returned to the the business model and asked if DHMS could take a strategic decision that hurt Discovery Health, given the "vested outsourcing model", which was intended to be mutually beneficial to the parties. The Trustee conceded that the outsourcing model meant that both organisations performed better in the way they worked together.

Mr Streak told the Panel about a study commissioned by DHMS about its governance structures. The Deloitte study came to the following conclusions:

- DHMS is led by a strong, independent board of trustees.
- The integrated model, in which DHMS outsources all its operation to one service provider, being Discovery Health) was effective in that it costs less (15% less than other open schemes) and delivers better performance.
- For every R1 spent, beneficiaries receive additional value of between R1.77 and R2.
- Members were R147 better off every year due to this business model. Members see this savings in the contributions they pay.
- There was an overall 27% reduction in administration fees between 2007 and 2012.
- The scheme outperformed all 13 of its open scheme competitors.

Mr Streak noted that the out of pocket expenditure was not included in the value formula because it was too difficult to quantify.

Scheme performance

The Panel heard that DHMS is very successful and is growing faster than other schemes. It maintains a solvency reserve of 12.9bn or 26%, which is 1% higher than the statutory minimum. An independent ratings agency has rated DHMS at AA+ (the highest possible rating for the last 15 years. It is currently the only open scheme with that rating.

In 2015, DHMS paid R33.3bn in claims, with the majority going to hospital, 39% to health care providers, and 10% of total risk expenditure on medicines. “Other”, which includes benefits such as emergency, blood transfusion, support services etc amounted to R1.2bn.

On average, a member contributes R32 100 per year. The top 10 claims cost R43 million, these include respiratory failure, heart disease, neonatal distress, TB (R3.3m). However, the sickest members (2% of members) consume 30% total expenditure.

Administration fees paid to Discovery Health amounted to 7.8% and brokers fees was 2% of expenditure. Mr Streak explained that DHMS had seen a dramatic decline in combined managed care and administration since 2008 and predicted that the fee will continue to decline to 10% and DHMS is aiming for fees to fall below 10% in the future.

Prescribed Minimum Benefits

On the topic of PMBs, DHMS indicated that it contracts with a wide range of designated service providers (DSP), which are critical to delivery of PMB. The PMB Code of Conduct, which has been discussed throughout the public hearings was said to be an important guiding document although it was in need of updating. When Dr van Gent questioned who was

responsible for conducting such an update, Mr Streak replied that it was for the regulator to lead. Dr van Gent asked why he described it as a dynamic document if it was out of date and a large player like Discovery could not take the lead in developing it. Mr Streak indicated that DHMS had suggested that it should be updated and was happy to be a key catalyst for its review.

Mr Streak suggested that its low cost KeyCare option had been successful in improving access to health care services. Approximately 30% of new members to DHMS join on the KeyCare option. Professor Fonn asked whether those numbers could be broken down to show members who were joining a scheme for the first time and not moving from one scheme to another. DHMS undertook to do the analysis and provide the Panel with the data.

Response to Kwanele Asante-Shongwe

The Chair requested that Mr Streak respond to certain of the concerns raised by Ms Kwanele Asante-Shongwe in her oral presentation, particularly related to the way in which she had struggled to obtain cover for various conditions to which she was entitled and the lack of information.

Mr Streak started by inviting her to next AGM taking place at the Convention Centre in Sandton in June 2016. Judge Ngcobo asked whether the agenda generally included an item for responding to members specific concerns. Mr Streak undertook to ensure that it would include such an item in the next AGM. Judge Ngcobo pressed on because her specific concern was that the importance of the AGM and other forums was not conveyed to members. While Mr Streak described how DHMS sends out notices in various forms and routinely got 500 RSVPs, he also stated that only about 200 members generally attended the AGMs. The Judge further questioned what DHMS could do to ensure that people not only received information but understood the purpose and use of the AGM so that they could attend.

Professor Fonn was interested in how accessible the Trustees of the DHMS were to members. “Not very much” was the answer, primarily because they are non-executives who are in full time professions. The members could approach the CEO’s office or Discovery Health for assistance.

Mr Streak was unable to answer Ms Asante-Shongwe’s concern about the fact that mental illness is treated differently by schemes, for example, repeated pre-authorisations needed and hospital costs will be paid while more long term and more effective out of hospital treatment is not.

Relationship with health care providers

Dr Bhengu put the concerns of some specialists to Mr Streak concerning what they see as interference with the treatment of patients through the clinical committees of schemes. One of the Trustees of DHMS suggested that the approach taken by DHMS was to include outside

experts as well as expertise in the UK and US on clinical committees. In particular, the Cleveland Clinic was mentioned as a source of expert opinion when there was a dispute between the clinical committee and clinician.

Information asymmetry

The Judge led the last round of questioning and focused on the interaction between member and scheme. Mr Streak stated that the system is complex. The Judge asked what happens when the complexity results in members not getting benefit timeously or losing life battles (referring specifically to a beneficiary who passed away before coming to give evidence to the Inquiry), asking isn't there something to be done? Again, Mr Steak fell back on the complexity of the system as the problem, stating that there are multiple stakeholders in the value chain and a fragmented system of delivering health care services and finally conceded that is should be more accessible. When the judge pressed further and said "miscommunication can at time be deadly asking 'How do we do that'? Mr Streak said he is not the expert but that better coordination of care and providers working in teams and with patient-focused approach would assist. The judge asked whether DHMS took the matter seriously enough to commission a study like the one Deloitte was commissioned to do on governance, the answer was no.

Financial Intermediaries Association of Southern Africa (FIA)

Following Discovery Health Medical Scheme, the Financial Intermediaries Association (FIA) made its oral submission. FIA is a not-for-profit organisation that represents the interests of brokers. The FIA told the Panel that brokers provided valuable advice to users and were a distribution channel for products. FIA said there were currently 24 open schemes in South Africa with 179 plan options across all of them, each with differing benefit structures and contributions.

The FIA admitted that brokers have had to, on occasion, explain how PMBs work and gave an example of a doctor who was uncertain of the process of the service. The services of brokers are defined in the Medical Schemes Act and FIA stated that the two elements relate to advice at the introduction of a member to a scheme and ongoing services.

These ongoing services include the handling of enquiries, instructions, complaints and claims for the members. FIA said that the broker should gather information on the client and then present their proposal and that if a member was unsatisfied with the service the client can terminate the relationship. FIA cited some of the services provided through employers to include:

- Operational support
- New member and dependant activations
- Wellness consulting

- Member training and education
- Consulting advice
- Billing and reconciliation of contributions
- Providing comparison tools

The FIA said that year-end was a crucial time for brokers. It was a time for plan updates from scheme and brokers undertook extensive communications including sending out newsletters and conducting road trips to assist clients to review and change their options. The organisation spent some time elaborating on the formal requirements brokers had to meet to practice, touching on minimum qualifications, regulatory exams and operational ability requirements.

Although the Medical Schemes Act does not prescribe who can employ brokers it does prescribe that a medical scheme may pay broker fees. FIA emphasised that fees for brokers were regulated and capped and were not a major cost driver. In fact it is not permissible for schemes to pay directly or indirectly any additional fees to brokers. The FIA suggested that the CMS report inflated broker fees by including scheme advertising and marketing in the fee.

Brokerage fees are built into the member's contribution. The FIA further explained that brokers' contract with schemes only to facilitate the payment of commission and that their service is to the member and their relationship with schemes is not an employment relationship.

Throughout, the Panel's requests for clarity the FIA maintained that there was no incentive to stick to one scheme as the remuneration was the same and those who had contracts with various schemes were independent and not compelled to give advice with favour.

This week's hearings concluded with a presentation from the Independent Practitioners Association Foundation (IPAF). Unfortunately, our team was unable to listen to their submissions. To view their presentation log onto the Competition Commission's YouTube channel https://www.youtube.com/watch?v=ni1R9J27OMA

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HMI: Licencing, RWOPS and Quality take centre stage

8 MARCH 2016

In today's session, the Panel sought to understand how the public and private sectors interact with one another. The Western Cape, Gauteng and KwaZulu-Natal Departments of Health all made oral submissions. All three provincial departments described the state of health services in the private and public health systems in their respective provinces, primarily using the indicator of the number of beds.

Several issues came up in all the presentations, including:

- the Remuneration for Work Outside the Public Sector (RWOPS) policy
- the barriers to entry for new entrants into the hospital market;
- legal framework and criteria for licensing of private facilities by provinces and the implications of the national certificate of need;
- the quality of care in private facilities, linked to that, the extent to which provinces share information about the quality of care with the public
- tariffs for treatment of medical scheme members in public facilities.

Western Cape Department of Health

Licensing

The presentation by the Department focused on the regulatory framework and process of licensing of private hospitals. The issuing of licenses for private hospitals is provided for in regulation R187 in the Western Cape. Some of the considerations that the provincial

department makes in deciding whether to grant a license are the bed to population ratio, the provision for a complaints mechanism, a track record of provision of quality healthcare and optimal use of space capacity. According to the accepted norms in the Western Cape of bed to population ratio previously neglected areas such as Khayelitsha and Mitchells Plain are undersupplied and others such as the Western Sub District are oversupplied. The Department accepted that it does not proactively direct private health facilities to the undersupplied areas and have simply focused on the adjudication of the applications they received for hospitals in areas which were appealing for applicants.

After a protracted exchange with the Chair of the Panel former Chief Justice Ngcobo on the potential duality of provincial and national legislation (certificate of need) relating to licensing of private facilities, it became apparent that the Department officials did not understand the status of the certificate of need provisions in the National Health Act. The provisions found in sections 36-40 were enacted by the President and then withdrawn through an application to the Constitutional Court because the regulations required for the implementation of the relevant provisions were not in place. The provincial officials also seemed to think that the provincial regulations concerning the licensing of private facilities would continue to operate even once the national regime had been implemented.

The Panel questioned the Department on the ownership of facilities and ensuring against perverse incentives which lead to over-servicing or corrupt referrals, a point which has come up numerous times in these hearings. The Department admitted that the regulations are outdated.

Public sector dumping

In respect of the "dumping" of patients from the private sector, the Department acknowledged that generating revenue is important and billing medical scheme for patients transferred to the public sector is an important source of income for the Department. However, the criteria for admission are purely clinical and no patients are refused services.

Quality

In response to the Panel's questions on how it tracked an applicant's quality of service, the Department said that it investigate public complaints and followed up on whether these had been resolved and considered the infrastructure of the facility. The Department conceded that it did not conduct a detailed 'quality of care' analysis, and that as far as assessing staffing levels, it required an applicant to disclose the number of nurses and a nursing plan in the initial application, but once the private facility was functional, further annual inspections did not take into consideration nursing or staffing ratios. The Department further conceded that it did not do enough to maintain and monitor national core standards in the private sector.

In final remarks, the Western Cape Department said it do not consider the financial viability of a facility at the initial stage of the application process as this does not fall within its ambit,

to which the Chair of the Panel expressed concern that this variable may impact on the quality of service provided.

Gauteng Department of Health

Next the Panel heard from the Gauteng Department of Health, which noted that comparably, South Africa spends more on healthcare than other low to middle income countries and should have better health outcomes considering its expenditure. Even though the Department did not elaborate on the lack of price regulation, its representatives agreed that this is a driver of the high cost of health care services in South Africa.

The Gauteng Department stated that the right of access to health care services guaranteed in section27 of the Constitution is not limited to the public sector and that the private sector also has a duty to exercise stewardship in regard to the right and put in place instruments which promote considerations of efficiency and affordability of health care services. The Department acknowledged that financial burden is inherent in the provision of health care services, but argued that access could be realised without catastrophic expenditure from users.

Gauteng has the highest population amongst all the provinces and mirrors the dual national health system. In the province, the private sector serves 28.2% of its population while 71.8% are served by the public sector. The Department stated that there are 18 833 hospital beds in the public sector in comparison to 16 276 in the private sector.

Licensing

The Department of Health in Gauteng indicated that it is guided by the old Regulation 158 made under the old National Health Act. The Department emphasised that there is a concentration of private hospitals in areas with a high population income, and that it received the most applications from these areas. Some of the factors the Department considered when adjudicating license applications are the promotion of equitable distribution, availability of human resources and health personnel, health needs, service demands and financial sustainability.

The Department grants licenses to applicants, which, for example, propose to render services to underserved areas or locations where the nearest hospital has a high bed occupancy rate and to cater for underserved health needs. The Department stated that applications were sometimes refused when they did not provide sufficient information about demand or proximity of hospitals belonging to the same hospital groups.

In the absence of the national guidance, the Department is drafting a policy to guide the licensing of facilities in Gauteng. However, the policy has not been finalised.

Barriers to entry

The Department wanted to dispel the notion that licensing limited market entry, noting that the number of private hospitals had increased from 95 in 2006 to 154 in 2015 with the use of these regulations.

The Panel questioned the Gauteng Department at length about the process involving new entrants merging with larger hospital groups after a license had been granted. The Department noted that while licenses were not transferrable, new applicants would often come back after approval saying that they may have underestimated the cost involved in opening and running a facility and sought financial investment from other hospital groups to partner with them in the venture.

Quality

The Department inspects hospitals during the application process, then at pre-registration to ensure that building specifications are met and then on an annual basis, which considers quality issues such as nursing care and staffing ratios.

The Department in response to the Panel indicated that it did not and was reluctant to publish information relating to these inspections, even though it agreed that the information may be helpful for patients and possibly enhance the quality of treatment. The Department has not previously published this information because of the potential for legal action being taken against it for publishing potentially adverse information about a hospital group. The department welcomed assistance of other bodies to enable for the publication of information related to quality of private facilities.

Like the Western Cape, the Gauteng Department does not appear to conduct adequate analysis of the financial sustainability when considering applications.

Kwa-Zulu Natal

Kwa-Zulu Natal is a largely rural province and the rural areas generally have a very low insured population and therefore no incentive for building private health facilities, the Panel heard from representatives of the Department of Health.

RWOPS

The Head of Department of the KZN department said that the RWOPS policy introduced in 2010 was detrimental to the public sector because it was abused by doctors. RWOPS was therefore suspended by the province and working in private sector whilst employed by the public sector is no longer officially sanctioned.

Treatment of TB

The HOD also confirmed submissions made earlier by some stakeholders that it is a practice in the private sector to refer TB patients to the public sector for treatment. The HOD said that public facilities did indeed have better practices compared to private facilities, for example,

the public sector has dedicated TB isolation wards with adequate buffers while private facilities did not. In respect of HIV, the HOD indicated that the public sector provided the better triple therapy while the private sector employed inferior dual therapy treatment.

Public sector dumping

The HOD went on to discuss the "dumping" of private sector patients on the public sector, often on an unfunded basis. When pressed about what he means by "dumping" the HOD explained that private patients who run out of funds were referred to the public sector to continue with the treatment and care of patients. An example was also given of patients who were admitted in a public hospital and were operated on the next day, indicating that the doctor involved was probably treating the patient in a private facility and then transferred the patient to the public hospital to conduct the surgery at a much reduced cost. However, such a practice prejudiced public sector patients because the theatre slot was taken up. Dr van Gent questioned the veracity of the claims about public sector dumping given the anecdotal nature of the claims and the lack of evidence presented on this point in the presentation. Dr van Gent suggested that it would be useful to get data in an objective manner about public sector dumping.

Licensing

Representatives reported that KZN follows a policy of a 25% to 75% split between private and public beds in the province. There are 7,843 beds in the private sector to the 23,527 beds in the public sector. However, the province is still short of 7128 hospital beds. The calculations of beds do not include beds in day hospitals.

The HOD indicated that the primary criteria for the assessment of applications for hospital licenses are secured funding, and a secured site for the hospital. In other words, the applicant must show the necessary financial backing for the project, a business plan, zoning permission. During the course of the application, applicants must invite comments from the public, which might include objections on several grounds, including the proximity to other existing private health facilities and environmental concerns. He said that a license includes conditions relating to infrastructure, bed spacing, internal policies, incident reports and nursing care standards. These standards must be shown to have been maintained during the annual re-licensing process.

Like in Gauteng, the primary legal instrument applied in the adjudication of applications for hospital licenses is the old Regulation 158, which was passed in 1980 in terms of a piece of health legislation passed in 1977. Dr van Gent questioned the use of such outdated regulations, particularly in light of modern understanding of how a health system should work. The Judge expanded on this by referring to the fact that the legislation is from the pre-constitutional era and that the principles and values introduced into our society by the Constitution should be reflected in the regulation of the health facilities.

Barriers to entry

The Judge also asked why it was that 64 licenses had been granted but the hospitals were never developed. After some prompting, it emerged that the non-completion of hospitals upon the granting of licenses was primarily linked to new and smaller entrants to the market as opposed to the established large hospital groups. The department has concluded that these ventures were not financial viable.

The Panel seemed concerned about barriers to entry for small players in hospital market.

Tariffs for treatment of private patients in public facilities

Professor Fonn asked the HOD about the capability of the province to bill medical schemes for services rendered in public facilities. The answer was that "we are not good but trying our level best" and that the province had invested in a more advanced billing system with the aim of increasing revenue for the province. However, this seems to be done on a hospital by hospital basis. One difficulty is that the province must utilise the ICD 10 codes used in the private sector, which requires extensive training.

Quality

The HOD made the extraordinary claim that no existing facility is with fully compliant with Regulation 158. The Judge asked how that could be so, when these facilities were allowed to continue operating. The developmental approach of the department was apparent in many answers given to the Panel. In one instance, one official said that they consider compliance to be a joint responsibility between the department and facility and that is why they gave facilities an opportunity to design their own plans to remedy compliance issues.

Inspections are frequently conducted to assess the quality of treatment. Inspections involve a walkabout in wards and reviewing documentation for accuracy, treatment protocols and standard of nursing care. The information is reported to the provincial department and the facility, which is given an opportunity to respond to adverse findings. When asked by Judge Ngcobo whether such reports were published for the public, the answer was that the department had never considered publishing the reports because of concerns that the reports might contain confidential information. The judge asked whether the department considered information about how patients are treated to be confidential. After much questioning, the HOD conceded that "we're scared of being sued". After further discussion, Judge Ngcobo suggested that the publication of quality information should be considered going forward because it is critical information for the public to know in order to make decisions about obtaining health services.

Panellist Dr Bhengu, enquired whether there had been any lessons learned from the public-private-partnership at the Albert Luthuli Hospital, which is a high-tech and award-winning hospital. The department indicated that the unique PPP financing model worked well and was

sustainable due to the strict management of contracts involving health services, hospital equipment, etc. When Dr Bhengu asked why such a model had not been replicated elsewhere in the country, the HOD deferred to the National Minister of Health.

The hearings continue with submissions from the Council for Medical Schemes and individuals on 9 March 2016 from 08:30.

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CMS delays prejudice patients, HMI panel discovers

9 MARCH 2016

The Acting Registrar, Dan Lechutjo led the CMS team in the oral submissions to the Panel. He was supported by Paresh Prema, General Manager of Benefits, Anton de Villiers, General Manager of Research and Monitoring and Nondumiso Khumalo Senior Researcher of Research & Monitoring.

The CMS focused on several key issues, including prescribed minimum benefits, the CMS complaints and appeal system, brokers and its recommendations for change, including a central independent authority for determination of tariffs.

The CMS is a statutory body that regulates medical schemes and brokers established in terms of the Medical Schemes Act, 1998 (Act). It is also a Public Entity in terms of the Public Service Act, 1994. CMS is the regulator for medical schemes, brokers and Managed Care Organisations. Its mandate includes regulating schemes, investigating and resolving complaints, collecting and disseminating information about private health care and advising the Minister on any matter concerning medical schemes.

The Minister of Health appoints the Council which comprises up to 15 members and it is funded through levies collected from medical schemes. During its presentation CMS representatives indicated that the allocation was insufficient, a point they raised with Treasury every year during the budgeting process.

The CMS employs 106 staff to carry out its extensive mandate which includes promoting access to health through four pillars: Open enrolment, community rating, PMBs and governance.

The CMS outlined healthcare spend saying it was at 79.9 cents on health related costs, 11 cents on non-health costs and 3.3 cents goes towards reserves. The out-of-pocket expenditure by medical scheme members was estimated at R20.7 billion based on claims that were submitted but not paid. This did not include amounts that were not claimed or were paid completely out-of-pocket by non-medical scheme members. The bulk is spent on medicines (33%) and specialist (25%).

Governance of medical schemes

All schemes are overseen by an elected Board of Trustees, which must appoint a principal officer. The trustees have a fiduciary duty to manage schemes in best interest of their members. Trustees can be removed and the scheme placed under curatorship in circumstances where irregularities or poor management (conflicts of interest, procuring services without following internal policies) is brought to the attention of the CMS. Including, for example, if there is not a sufficient arms length relationship with the schemes administrator. The CMS has placed about 14 schemes under curatorship since 2001.

The CMS said it was concerned about what it calls "poor attendance" of members at the schemes' annual general meetings at which this kind of information should be available. During question time, the chair of the Panel asked the CMS what measures could be put in place to address this problem.

In order to assist schemes with their governance, the CMS has started a training programme for trustees through a SAQA approved course. In the most recent round, 10 out of 40 attendees of the course qualified and were declared competent to be trustees. CMS provides similar training for brokers. In addition CMS introduced a self-evaluation tool.

Complaints process

Most complaints that the CMS receive relate to PMB benefits as well as:

- Limits imposed on cover;
- Misunderstanding of how designated service providers (DSPs) work, primarily due to miscommunication by schemes;
- Involuntary use of non-DSP;
- Confusion about coding of services, primarily when schemes dispute codes used by practitioners; and
- Remuneration of trustees.

The panel has heard complaints about the CMS's complaints system from members of medical schemes who have appeared before the Panel. The CMS explained that it aims to have a transparent, equitable, accessible, expeditious as well as a reasonable procedurally fair dispute resolution process.

The CMS also explained that urgent complaints are dealt with extremely expeditiously, requiring schemes to respond within 24 hours making a ruling within 120 days from date of referral.

The CMS also acknowledged the problematic aspects of the appeals process, including the fact that the Appeals Committee meets only once a month and have limited time to adjudicate disputes, leading to a backlog. After the initial appeal, there are two further layers of appeals. In addition, the rulings of the CMS may be reviewed in the High Court.

The CMS representatives seemed to struggle to answer Dr Nkonki's question about the CMS statement that there is no reason for members to be financially disadvantaged given that there is a clear indication of whether the claim should be covered when a dispute is raised. She explained that the statement does not take account of the fact that members must pay upfront for services whilst the dispute is pending, which financially disadvantaged them, particularly in light of the delays within the complaints system. The CMS representatives,

after numerous questions from Dr Nkonki, conceded that members were indeed financially disadvantaged.

The Panel pressed the CMS representatives on what appears to be a complaints system that does not work for the people it should protects, the individual members. The CMS seems to be adjudicating the same cases over and over again with members raising the same complaints, albeit in respect of different schemes.

Chief Justice Ngcobo asked whether the CMS rulings were published and circulated. The answer was that the rulings are published but not circulated to other schemes that may encounter similar complaints. Chief Justice Ngcobo asked very pointedly 'do you have the power to enforce your rulings'?

Regulatory features and concerns

The main concerns raised by the CMS in respect of the regulatory features in the sector were information asymmetry experienced by members and the lack of pricing regulation. CMS also noted that while there had been discussion about who were the price takers in the sector, it was the patient that was really the price taker as they don't have sufficient information, cannot negotiate fees with providers and are responsible for the cost if providers and schemes cant agree on a fee.

The CMS said it tries to address the information asymmetry through ongoing education of the public and guidance to schemes.

The CMS was also concerned that schemes are not transparent about the designation of service providers and do not seem to collect data about cost-effectiveness, quality of care and affordability. For example, some DSPs have a higher fee structure despite the economies of scale that come with larger schemes.

Dr van Gent asked whether the CMS's work on the Risk Equalisation Fund was ready to be implemented. The CMS representative indicated that the model is available but the systems were not in place to implement. The CMS would be able to get it ready within two years with the necessary resources.

Administrators

The three largest administrators are Discovery health (27%), Metropolitan Health (25.3%) and Medscheme (27.2%). The relationship with schemes should be an arms length one but it is not always the case. In response, CMS issued an Undesirable Business Practice Declaration to ensure that schemes and administrators are clearly demarcated.

Quality of care

The CMS has only recently begun to analyse quality of care received by members of medical schemes. It has started by looking at several indicators of quality through the lens of 9

chronic illnesses. Chief Justice Ngcobo asked, as he has asked other presenters, about how CMS deals with and disseminates information about the quality of facilities? The CMS representative could only answer that it has stated collecting such data in 2015 and could do more to address health outcomes.

Prescribed Minimum Benefits

PMBs are meant to protect members from catastrophic events. While schemes complain about the abuse of PMBs (for example, practitioners coding health services as PMBs that not actually PMBs), CMS is of the view that there is no evidence to show that PMBs are a significant cost driver or that there is widespread abuse.

The CMS also addressed some of the concerns raised by stakeholders about the rigid application of scheme formularies for drugs. The CMS indicated that formularies must be evidence-based and cost effective, which does not necessarily mean the cheapest drug. Schemes should also have protocols for alternative treatments if formulary drugs are not appropriate for a patient.

Concerning the often-cited requirement that the PMBs must be reviewed every 2 years by the Department of Health (DOH), the CMS stated that it had prepared a full review to the DOH in 2010. This was the result of consultation with industry experts and included updated cronic disease list algorithms and cleaned up the disease treatment pairs (DTPs). It also included greater cover for mental health conditions – the limited cover for mental health has been raised again and again in these hearings. CMS made a further submission to DOH in October 2012. However, in 2014, the DOH advised that it should include more primary and preventative care. The CMS then proceeded to work on primary health care services package to be included in the PMBs. In December 2015, CMS halted the process in light of the publication of the National Health Insurance White Paper because of the stance taken in respect of medical schemes. CMS said it needed clarity on the package of services because according to the White Paper, medical schemes cannot offer duplicate benefits provided by the NHI. In other words, if primary care is being offered through NHI, it is unclear whether schemes can offer a primary care PMB package. Upon questioning by Prof Fonn, the CMS conceded that it must continue with the process in order to protect members of schemes regardless of the long term NHI policy process.

Dr van Gent requested a copy of the 2010 review of PMBs and the process that followed the 2010 review, together with timelines and interaction with DOH.

Health insurance products

The insurance companies made oral submissions to the Panel on 2 March about why health insurance products are valuable and should be allowed to co-exist with medical schemes. The CMS has no 'in principle' objection to these products. However, such products should not undermine the social solidarity principles in medical schemes. In other words, insurers

should not discriminate by age, gender or any other category, should disclose information concerning marketing and should, most importantly, not replicate benefits offered by medical schemes.

Reforms to legal framework – Draft Medical Schemes Bill

The CMS has drafted an amendment to the Medical Schemes Act to address some of the shortcomings in the present act with respect to:

- Information management
- Membership and contribution related issues
- Updated complaints and appeals processes
- Enhanced governance to address conflicts of interest amongst trustees
- Update definitions in the Act
- Powers to establish to guidelines
- Enhanced enforcement mechanisms
- Reporting structures into CMS
- Extended limitation of liability
- Payment of brokers fees by members rather than schemes

Relative strength of CMS as a regulator of the medical schemes industry

Dr van Gent asked about the balance of powers in respect of the powerful players that the CMS regulates. The Registrar answered that the law creates a balance of power but because of limited resources the CMS cannot sufficient enforce the various provisions of the Act. Dr van Gent then asked whether the 'arms length' principle is effective if players like Discovery, as described by individual members who appeared before the Panel, do not comply. The CMS representative responded that the need for enforcing the principle led to the publication of the undesirable practice declaration. Dr van Gent then commented that if the CMS failed to enforce the Act and its rulings, it was left to individual beneficiaries to chase powerful companies to comply.

Chief Justice Ngcobo intervened to relay the story of the previous presenter, Ms Narunsky, who waited almost two years for the conclusion of a dispute with Discovery. The CMS explained that delays were caused due to outstanding clinical information. In that particular case, the CMS found in favour of the member. Discovery appealed but then withdrew its appeal at the time it was set down for hearing. At this point it had been almost two years

since the institution of the dispute with CMS. Chief Justice Ngcobo wanted a proper and accurate explanation of the delay in Ms Narunsky case. He said, 'if its true, then something is wrong with your system'. The CMS representative eventually conceded that there was an inordinate delay in this case and undertook to revert with all the details.

Dr Bhengu inquired whether the reports of CMS are widely supported by the industry as a whole or had there been challenges. Ms Khumalo responded that there had been a few queries from providers about the data and that CMS took the approach of collaborating with providers as it has no other way to collect data from hospitals and doctors, as the mandate does not extend to suppliers.

Finally, Dr van Gent asked whether a reinsurance agreement between schemes and a dental managed care organisation, Denis, which allowed Denis to profit beyond the fees paid by the scheme, was legal. In the example given, the scheme paid Denis a fee of 28% on the R300 million set aside for dental cover, with the agreement that any savings made on top of the fee was to be retained by Denis as profit. The CMS had difficulty with the question and eventually answered that if the arrangement amounted to a bonus to directors, it would be illegal as that was prohibited by the Act. However, it transpired that the CMS accredited Denis and may have had sight of the contract during the accreditation process. The Panel seemed taken aback that such an arrangement could have passed the scrutiny of the CMS.

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Anguished mothers share frustrations with HMI panel

10 MARCH 2016

The day began with two mothers and their children presenting to the Health Inquiry Panel about the challenges that they had in accessing healthcare services for their children. Both Kyle Drescher (19) and Jessica McCarthy (24) gave moving testimony about their personal challenges in accessing medical treatment for conditions that they submitted ought to have been covered by Discovery Health because they fall within the legally mandated list of Prescribed Minimum Benefits (PMBs).

Cheryl Narunsky and Jessica McCarthy

In 2012 Jessica McCarthy was in a car accident and sustained a Traumatic Brain Injury. Describing the severity of her condition after the accident Jessica said "I was the most vulnerable I have ever been… I couldn't bath myself or walk". As a result, her mother Ms Narunsky dealt with Discovery Health on her behalf.

Ms Narusky states that she initially had no understanding of what PMBs were. Without excellent support from medical practitioners "I wouldn't even have known that PMB legislation existed", she said. Jessica also confirmed that "no one had explained to me that was being denied was a PMB. I didn't even know what a PMB was. Discovery actually concealed to me that I actually had many more benefits".

Ms Narunsky told the panel that with Jess at home for 13 days, despite her serious need to be admitted to a "rehabilitation hospital" Discovery "employed various tactics to delay the authorisation" for admission and that it "kept making random excuses". The rehabilitation Jessica required including professional physiotherapy, occupational therapy and speech therapy. Fed up, Ms Narunsky created a Facebook group titled "How I was messed around by Discovery Health Medical Aid". The group now has over 1000 members.

In order to have Jessica's medical expenses paid Ms Narunsky said she had to make constant and repeated email and phone call inquiries to various people at Discovery Health. Ms Narunsky noted that the "medical panel" of Discovery that made the decision to deny Jessica's claims never met with her or Jessica and "ignored reports from more than 23 medical professionals". Despite efforts Ms Narunsky says she could not get any more information about who the members of the anonymous medical panel were, and therefore had no way of laying a complaint. Discovery merely said that the information was "confidential". Ms Narunsky noted this is a common experience of members on the Facebook group she started. A member of the Panel commented that it is "quite unacceptable" that a patient is prevented from laying a complaint against medical panels within schemes.

After a year of trying to appeal Discovery's decision internally, she gave up and turned to laying a formal complaint with the Council for Medical Schemes (CMS). After a further 11

months the CMS ruled in Jessica's favour finding that "the Scheme is not correct in the level of PMB benefits it afforded". Ms Narunsky decried the fact that Discovery then took a further year to "decide whether or not it would appeal". She told the Panel she would like to express her "disgust" that during this time Discovery's legal team even "stalked Jessica's facebook page" to try and bolster claims that she no longer required treatment. The Chief Justice asked Ms Narunsky whether the CMS kept her and Jessica informed about the process during lengthy delays, and she responded that it had not done so sufficiently.

Ms Narunsky said that Dr Jonathan Broomberg, the CEO of Discovery Health, later on conceded in personal correspondence that "the matter should not have been set down for appeal in the first place" but that the appeal had been aimed at preventing the bad precedent of the CMS ruling may set for the future and its financial implications for Discovery. She noted, however, that Dr Broomberg's position appeared to change as time progressed.

Ultimately Ms Narunsky concluded that "It is quite simply not my problem that it is inconvenient for Discovery to pay out PMBs". She noted that though Discovery has now paid out nearly R90 000 for Jessica's rehabilitation that despite her "meticulous records" Discovery had "ignored approximately R35000 worth of claims" and that the payments promised themselves "fell short" by R17000. Clearly emotional about her ordeal, she concluded that "I don't feel like our needs have been addressed yet". Ms Narunsky commented that she had been pushed so far during the process as to have been forced to sell her house "to continue funding the costs incurred" while awaiting payment from Discovery.

In presenting and answering the questions of the Panel Jessica described how the whole process had felt to her. "I was not in a position to deal with the duckings and divings of Discovery" she said. Repeating comments made by patients and patients group made in Pretoria to the Panel last month she said "I don't know if I can do justice to how overwhelming it feels… I trusted Discovery with my life" and "it feels like David and Goliath – [Discovery] just don't care about one small person". She explained that she would have moved to another Medical Scheme but there is a "12 month waiting period for preexisting conditions" which prevents patients like her from even changing schemes when they are very poorly treated. For her part Ms Narunsky put down Discovery's conduct to either the "trickery" of a "slick" company or "gross incompetence".

The Panel also asked both Ms Narunsky and Jessica whether they knew the difference between Discovery Health Administrator and Discovery Health Medical Scheme. Both indicated that for the majority of their interaction with Discovery that they did not. Ms Narunsky replied that Dr Broomberg gave off the impression to her that he represented Discovery as a whole during their interaction. Chief Justice Ngcobo then inquired whether they had ever been contacted by anyone from the medical scheme itself and they responded that they had not.

Kyle and Angela Drescher

Kyle Drescher's mother, Angela Drescher made submissions about her son and husband's treatment by Discovery on the opening day of the public hearings of the Panel in Pretoria last month. Kyle's submissions were intended to specifically articulate his personal experience. Kyle was diagnosed with a major depression which was so severe that he had to be removed from school and his mother closed down her business to take care of him full time.

Kyle highlighted the inadequacy of the Prescribed Minimum Benefits in the case of mental health conditions. He said that he and his mother were informed that the PMBs only cover comprehensive bipolar depression not major depressions like his, "I was told I only had cover for therapy if I had bipolar." As a result of this lack of understanding and knowledge, Kyle had to be admitted to a hospital falsely diagnosed by a health professional as having bipolar depression. As South African Depression and Anxiety Group and others noted in their submissions health professionals who are desperate to get patients some treatment that will be covered by medical schemes routinely admit patients to hospitals when it is not the ideal treatment. Kyle repeatedly questioned "why will Discovery pay so much for hospital admission and not therapy for depression outside [of hospitals]?". He described struggling in the hospital "I felt like a criminal locked up in a facility. It felt like a punishment."

Having returned home on the advice of a psychiatrist because he could not manage in the hospital environment, Kyle said his mother discovered that Kyle was entitled to 15 sessions with a psychiatrist per year outside of hospital for his depression. Frustrated that Discovery would not pay, Kyle's mother Ms Angela Drescher, turned to HelloPeter.com – a consumer complaint website – to complain about Discovery's treatment of her child. Kyle noted that this website receives thousands of complaints about Discovery and that during the Health Inquiry process Dr Jonathan Broomberg, the CEO of Discovery Health, "messaged my mom on Facebook and told her to stop telling people at at the Health Inquiry to complain on HelloPeter.com". He noted that though Discovery now pays for these sessions after the complaint his mother made on HelloPeter.com that "15 sessions a year is not enough to deal with depression and anxiety – especially for a teenager."

Like Jessica, Kyle spoke with feeling and questioned why "neither doctors nor Discovery explained PMBs were entitled to be paid in full by law". He said he was confused by the fact that out of the 343 pages of PMBs in the regulations, depression and anxiety are not fully and comprehensively dealt with. He concluded by asking "why did my family, especially my mom, have to go through such trauma to have PMB benefits paid?" He told the Panel that there was "chaos in my home caused by Discovery".

Allied Health Professions Council of South Africa

The Allied Health Professions Council of South Africa (AHPCSA) is a statutory health body established in terms of the Allied Health Professions Act. Eleven allied health professions, including Ayurveda, Chinese Medicine and Acupuncture, Chiropractic, Homeopathy, Naturopathy, Osteopathy, Phytotherapy, Therapeutic Aromatherapy, Therapeutic Massage

Therapy, Therapeutic Reflexology and Unani-Tibb fall within its ambit. The AHPCSA noted that "there are over 2600 registered Allied Healthcare practitioners in SA".

The AHPCSA said that the entire Health Inquiry was a "Disease Inquiry" and was focusing mostly on diseases and the treatment of diseases, whereas one of the major advantages of some of the professions represented on the AHPCSA is that they focus on proactive prevention of ill-health.

The AHPCSA emphasised allied health professionals rights to "freedom of trade, occupation and profession" in terms of section 22 of the Constitution and said that this was regularly disrespected by medical schemes who attempt to decrease costs by not paying out claims stemming from services provided by allied health professionals: "they routinely refuse to pay… either because of a lack of understanding or prejudice". This is so, in the AHPCSA's submission, despite the fact that the costs of reimbursing allied health professionals are an extremely small fraction of all claims paid out by medical aids in South Africa. For example, there were "only" R42.5 million in reimbursements for homeopathy from medical aids for 2013/14.

The AHPCSA concluded by submitting that it is difficult to avoid the conclusion that medical aids were discriminating against allied health professionals because of "ignorance". They emphasised that section 27 of the Constitution entrenches the right to access to healthcare "services" not a single type of "service" alone.

When asked by the Panel what recommendation it should take the AHPCSA said that allied health professionals wanted to be treated equally and have claims relating to their services paid by medical aids.

National Hospital Network

CEO, Kurt Worrall-Clare led the National Hospital Network (NHN) submission. The NHN, a not-for-profit and voluntary association for independent hospitals, facilitates negotiations between members and funders across the country. Its membership has grown from 70 hospitals in 2010 to 177 to date. Worall-Clare attributed the market viability of stand-alone hospitals to the exemption provided in Section 10 of the Competition Act. Worall-Clare said that the exemption which NHN was granted by the Commission has been able to protect smaller hospitals from acquisitions by the big hospital groups and serves as an important tool to encourage competition.

Licensing of Private Hospitals

NHN argued that provincial licensing of private hospitals creates impediments for entry. Worall-Clare stated that since the decentralisation of licensing from national to provincial competence, some of the provisions which were adopted from the National Health Act of 1977 for provincial use render the process inoperative as they relate to national authorities.

NHN noted that some provinces had developed their own regulatory framework such as Regulation R158. However they asserted that their members experienced challenges in the application of R158 such as inconsistent interpretation, no clear criterion on which applications were considered, new criteria continually being introduced without transparency and a lengthy and costly appeals process for rejected applicants. NHN also commented that Regulation R158 is 30 years out of date and does not take into account the different types of private facilities applicants propose to develop. Worall-Clare said NHN would like provincial departments to carve out of the existing framework a provision to cater to the different needs or facilities which applicants requested a license for. The National Health Act also does provide not for different categories of health facilities. NHN recommended a comprehensive unpacking of Regulation R158 and the certificate of need referred to in the National Health Act which considers the distinctions between facilities and how to license establishments accordingly.

Designated Service Providers (DSP) & PMBs

NHN said that DSP arrangements are a significant component of the Medical Schemes Act but argued that they are largely not regulated and that there is no provision which talks to applicable principles, transparency or how DSPs are appointed. This flaw in the process they said is a barrier for independent hospitals in entering the market or becoming DSPs. NHN advised that some schemes have indicated that the criteria is quality and cost effectiveness however there is no clear and transparent information on the criteria and this excludes small hospitals from becoming DSPs. DSP arrangements prevent NHN members from treating patients whose nearest DSP is very far as schemes refuse to reimburse even when independent hospitals have indicated that they are prepared to meet the terms of DSP for those members who reside near independent hospitals.

NHN recognised that DSP agreements as envisaged in the Medical Schemes Act are a useful mechanism to mitigate against exposure to abuse of Regulation 8 and said that if the provision for DSPs is utilised effectively it can be beneficial to members and schemes. However the lack of criteria or guidance on who can compete to become a DSP needed to be interrogated and the information relating to the arrangements was not easily accessible as the contracts between schemes and hospitals are confidential.

Further, NHN commented that Provisions 6 – 8 of the National Health Act require a service provider to offer a user information relating to their treatment options and related costs. NHN's position is that an obligation on providers to explain PMBs is onerous and goes beyond what is envisaged in the legislation. NHN admitted that identifying a PMB might be incidental in an explanation relating to cost, but said that asking them to explain how to access the benefit pushes service providers to enter the domain of making representations on behalf of medical schemes and the that function is the primary responsibility of administrators.

Negotiating with Administrators and Schemes

The Panel was interested in the interaction and balance of power between administrators and independent hospitals. NHN indicated that they preferred to negotiate reimbursement models with schemes rather that administrators, especially when the administrator is providing services to various schemes. NHN said that the issue, with what Dr Bhengu termed a 'multi-scheme' administrator is that these administrators have a single set of rules which apply to all the schemes they are employed by, with provisions which may not be applicable or practical across the schemes and their associated costs and needs. However NHN said there are some administrators, such as Discovery and MMI which insist on negotiating on behalf of the schemes. NHN said that the practical impact of negotiating reimbursement models with administrators precludes them from designing scheme specific agreements.

Other Issues

NHN agreed with some of the schemes affirming that the reserve rates required for solvency is too high in comparison to the international market. Worall-Clare said that money is just sitting in reserve banks which can be freed up for member benefits and encouraged radical decrease on money kept for reserves to ensure solvency requirements are met.

On the issue of hospitals employing health professionals for cost effectiveness, NHN considers the initiative more complicated then schemes anticipate and said that schemes need to take into account the dynamics of our current market. NHN said that the consequence might be that big hospital groups which can meet large employment packages would be advantaged over independent hospitals which could not meet the same demands. This they said could lead to diverting skills of specialists from general accessibility and focus it on the entities which employ service providers.

Hearing continue on 10 March 2016 with presentations from Life Healthcare Group, Mediclinic and Netcare.

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"SA needs more doctors" Netcare tells HMI

18 MARCH 2016

Netcare Hospital Group

Melanie Da Costa, the Director of Strategy and Health Policy at Netcare Limited led the oral submission to the Panel. Netcare has 57 hospitals across Lesotho and South Africa and holds a 54% stake in BMI Healthcare in the United Kingdom (UK). In 2015, Netcare opened hospitals in Polokwane and Pinehaven, and has invested over R8 Billion over the last 8 years in capital expenditure. The group operates 5 nursing colleges and has trained over 40 000 nurses since 1999. Netcare told the Panel that it would like to participate in the education of doctors but are restricted by regulation. Ms Da Costa spoke about various corporate social investments Netcare has made such as community sponsorships, bursaries, indigent EMS, over for public sector strikes and other initiatives in which they partner in extending free access to healthcare. Ms Da Costa also highlighted Netcare's co-operation with the public sector giving examples of their Public Private Partnership (PPP) in Lesotho drawing attention to the structural differences between South Africa and Lesotho. However, according to the Minister of Health, Dr Aaron Motsoaledi, Netcare's PPP has received concerning criticism from Lesotho's Minister of Health. Professor Fonn also raised some criticism made by the World Bank, which was a key funder of the project.

Relationships with other Stakeholders

Mark Bishop, the Head of Business Services at Netcare said that sometimes their relationship with medical schemes is fraught. Before a patient can be admitted by a doctor they must receive pre-authorisation from their scheme, which considers the care they can received based on he benefits the member has. Mr Bishop stated that the authorisation does not however guarantee payment, and that sometimes hospitals have to continuously engage with schemes when complications occur during a patients hospital stay to extend authorisation. Netcare emphasised that hospitals don't engage in the choice of treatment, referrals or admission of patients, and that these decisions are made by doctors. Mr Bishop advised that the accounts bill gives an unusual amount of information and that there are different accounts for doctors, the hospital and radiology (when applicable). Doctors negotiate their own tariffs independent of the hospital and do not participate in hospital revenue and that their only earnings were from their bills, as shareholding by doctors is not permitted at Netcare hospitals. Netcare has annual hospital reimbursement negotiations with medical schemes which are generally on a national basis or are included in the Designated Service Provider (DSP) arrangements. Netcare differed with National Hospital Network saying that Managed Care Organisations make geographical considerations when making DSP arrangements to manage reasonable access.

The representatives of Netcare raised the prohibition against hospitals employing doctors, citing examples of Netcare hospitals employment of doctors in Lesotho and in the National Health Service in the UK, which had proved successful.

Netcare informed the Panel that emergency departments in their hospitals are run by independent practitioners, with whom hospitals have service level agreements, saying however that if hospitals could employ doctors, quality could be better controlled and this could simplify accounts for patients.

Netcare provides users with information regarding the admission and discharge process, the service provided, what to expect with the procedure and what to look out for once a patient is back home. Other information which appears on their website or pamphlets relates to the emergency department, self-payment, services provided, information relating to specialists, a complaints process, pricing guidelines and maternity or surgical admissions.

Netcare also spoke in detail about their quality leadership framework which encompasses operational excellence, best & safest products, growing with passionate people, physician partnerships and accelerating transformation.

Regulatory framework

Anthony Norton, one of Netcare's attorneys acknowledged that regulation is important especially in the health sector. However, it can become burdensome, constrain innovation, limit competition and lead to increased costs, especially in South Africa's healthcare environment. Mr Norton said that the existing regulation restricts efficiency using the exclusion of hospitals from training or employing doctors and limitations on sourcing medication in the most cost effective ways as examples.

Netcare criticised the Medical Schemes Act saying that it introduced social solidarity principles such as PMBs, open enrolment, fixed solvency ratio's and community rating, which were intended to be counter-balanced with further regulatory reform. Netcare said that the failure to establish further regulation has hindered sustainability of the system. The 25% solvency gross contribution from schemes does not account for the schemes size, risk profile, capital arrangements or whether the scheme is making a surplus or deficit. This, Netcare said has led to money being held up unnecessarily which could be used to benefit members. Netcare further asserted that open enrolment precludes schemes from differentiating between low and high risk beneficiaries which leads to adverse selection. They compared open and restricted schemes noting that restricted schemes, which face less adverse selection have experienced lower contribution increases over time.

Mr Norton also commented on the findings and recommendations of the Ministerial Task Team (MTT) set up by the Minister of Health to investigate issues of maladministration, irregularities, mismanagement and poor governance at the Health Professions Council Of South Africa (HPCSA). The MTT found that the HPCSA failed to carry out some its core

functions such as examining and recognising foreign qualifications, carrying out professional conduct enquiries and approving the programmes of training schools.

Netcare agreed that the HPCSA is dysfunctional and the issue is particularly concerning because the country has a shortage of health professionals. Netcare emphasised the limitations on private bodies to train professionals proposing that the inadequacy in training capacity indicates a need for private medical training.

Netcare reiterated the concerns of the other private hospital groups regarding provincial licensing for private hospitals. Netcare's dissatisfaction with the process of licensing is that it is fragmented, unresponsive at times, inconsistent and applies the same time periods for licensing a new hospital and expanding or changing the use beds at existing facilities.

Other Issues

Netcare said that it is not simple to compare hospital prices across borders, but admitted that the issue of affordability is a serious challenge in South Africa. Like the other major hospital groups Netcare quoted payroll, drugs and consumables as high operating costs for hospitals. Also, touching briefing on utilisation as a driver of costs. Mr Norton raised some concerns regarding the risks associated with price regulation saying it is difficult and costly to set up, discourages new entrants and generates distortion risk.

Lastly, Senior Counsel for Netcare, David Unterhlater, cautioned the Panel against exceeding the the scope of the Inquiry as empowered by the Competition Act, saying it can examine factors which restrict or distort competition and consider remedies to cure such risk. However is should not be concerned with questions about whether there should be regulations to alter market based outcomes.

Questions from Panel

The Panel was interested in the relationship between Netcare and administrators who negotiate reimbursement agreements on behalf of more than one scheme, to assess whether the activity is competitive. Unlike the National Hospital Network, Netcare finds that the relationship with 'multi-scheme' administrators enables the process. On the subject of licensing, Netcare confirmed that licensing is a barrier but that it has not precluded new entrants, which were sometimes favoured by the process. Netcare said that it is sometimes approached by new entrants that have received licenses to partner with them because of a lack of expertise or funding but that there have been competition implications which complicate these affiliations.

Professor Fonn raised an essential consideration regarding the argument that the burden of disease is a cost driver making the differentiation between the total population and those that are medically insured saying that the burden of disease is disproportionately borne by those who are not medically insured.

On the recurring theme of information asymmetry and quality, Panellist Dr van Gent asked whether Netcare considers itself to be responsible for providing comparable information to public about the quality of its services in comparison with other service providers. Netcare indicated that it was indeed responsible but in the absence of standards, its immediate responsibility was to contribute to an agreed methodology for measuring quality and to then to cooperate with the Office of Health Standards Compliance (OHSC) to ensure that the data was complete and accurate. Netcare went on to say that it is willing to continue with the process with speed and urgency.

When asked by the Panel what change would make the most difference to Netcare, Ms De Costa said that more doctors would make the most difference to their ability to deliver health services.

The Health Market Inquiry resumes on Tuesday 29 March 2016

Smaller entrants struggle to compete in Private Healthcare Sector

5 MAY 2016

On the second day of this round of hearings, the Panel heard from the Clinix Health Group, the South African Nursing Council and Office of Health Standards Compliance. Testimony from each of these groups was extensive and lengthy as a result summaries of these proceedings will be published individually.

History and Structure of Clinix

Clinix Health Group was founded in 1992 by Dr Peter Matseke and presently operates 8 hospitals with 1450 beds in Gauteng, Limpopo and North West. Dr Matseke's undertaking to bring private healthcare to previously disadvantaged communities was regarded as a major risk within the medical industry at the time. Currently Clinix is investing aggressively in world class facilities and the employment of nurses, cleaning staff and community based caregivers from communities in which its hospitals are based. Prior to establishing Clinix, Dr Matseke ran a successful medical practise working as a medical officer in the surgical department at Chris Hani Baragwanath Hospital.

Business Model

The group provides infrastructure, clinical services and bills for services rendered. The role of the doctors is to manage clinical processes, admit patients and they bill separately for their services. In addition, Clinix uses specialist services such as radiologists who act on the instructions of the referring doctors. The services account includes accommodating charges, theatre billing, equipment charging and pharmaceutical items.

Clinix hospitals serve communities where most of the people are low income earners and the majority of which are not medically insured.

Regulation and Staffing

The Clinix representative who led the submission spoke briefly about regulation in the health sector, quoting the National Health Act, Medical Schemes Act, the Constitution and National Core Standards Compliance as some of the relevant legislation. He said that even though regulations are important, and especially in the health sector they can become burdensome, constrain innovation, limit competition, and lead to increased costs. Adding that regulation restricts the use of doctors and nurses from abroad. Further, Clinix observed that there is a huge shortage of sufficiently skilled nurses and told the Panel that Clinix focuses on training and encouraging continuous learning. Clinix outlined the guidelines which it operates to ensure patients safety and quality care, making specific mention of its Physician Advisory Board (PAB). The PAB is an autonomous committee which explicitly focuses on clinical matters and the quality of care within Clinix hospitals.

Relationship with Funders

Clinix recognised that Designated Provider Networks provides administrators the ability to channel significant volumes of patients to specific providers. It would make sense they added if these DSP's included Clinix facilities because of the locations of Clinix hospitals, however this is not the case. They used the Discovery KeyCare plan to make the point, drawing to the Panel's attention the fact that medical schemes do no reimburse service fees for members who do not use a network hospital or network specialist. This they said puts hospitals and specialists in the areas they serve at risk of non-payment.

Clinix lamented the imbalance in negotiating power with bigger schemes stating that this hindered its ability to compete. Clinix asserted that funders, in the endeavour of curbing escalating costs, have embarked on measurements of quality outcomes which compare Clinix with other listed hospitals. Clinix contends that this comparison is inappropriate because the impact of social ills and diseases patterns prevalent in the areas which Clinix serves is dissimilar to that in affluent areas. For these reasons, Clinix argued, the measurement of length of stay spend by patients cannot be expected to be the same.

Dr Matseke said there remains a lack of interest and funding in developing hospitals in townships because these areas are perceived as high risk.

Clinix patients are those who are on cheaper medical aid options and the implication is that Clinix is paid lower tariffs. Bigger groups he said had more bargaining power and could negotiate better tarrifs. Dr Matseke explained that without the necessary funding, new entrants would find it impossible to compete. Also, that hospital groups such as Clinix find are challenged in competing for specialists because they do not have the same facilities and equipment. He added that because of the non-payment by schemes and types of medical aid plans low income earners chose it was difficult for Clinix to attract specialists. In response to Chief Justice Ngcobo's probe, Dr Matseke said: "Cheaper medical aid plans are restrictive, and the criteria used to chose DSP's considers specialist services which is prejudicial to smaller groups as they are unable to attract specialists.

Dr Matseke put forward the proposal that the National Department of Health should set the rules regarding the licensing of private hospitals and the provincial departments should implement as they are closer to the issues. According to Dr Matseke the application process for licensing of private hospitals is not a barrier, in and of itself, but that new and smaller groups are unable to access capital to develop hospitals.

In the past, the Industrial Development Corporation had funded new entrants but no longer does, further limiting avenues for access to capital. Dr Matseke suggested that medical schemes should be allowed to fund new entrants to create access for their members

Nursing shortages dominate Council's presentation to Health Market Inquiry panel

5 MAY 2016

Acting Registrar Mrs T Manganye along with two representatives presented to the panel Health Market Inquiry on the role and functions of the Nursing Council of South Africa.

What is the Nursing Council?

The Nursing Council is a statutory body set up and operating in terms of the Nursing Act. In 1998, the first democratic Nursing Council was established. The Council is made up of various committees and includes significant membership of nurses who are nominated based on their expertise by members of the nursing profession. Other members include representatives of the Department of Health, members with expertise in law, consumer affairs and education and three community representatives. Details about different committee's membership can be found on the Council's website.

The Council has various statutory responsibilities, which include understanding and applying national health policy, managing the quality of the training of nurses, publishing a register of nursing practitioners and receiving complaints about members of the profession. The Council also determines the scope of practice for nurses with different specialisations and has produced a code of conduct for the nursing profession. The exact scope of the Council's "jurisdiction" and the scope of its mandate was interrogated by Panel members throughout the Council's presentation.

Complaints

The Acting Registrar of Nursing Council explained that the Council can investigate complaints about nurses from hospitals, medical professionals and even members of the public. The Council will also act on complaints emerging in the media. Nurses can also be report directly to committees within the Council such as its ethics committee and its professional conduct committee.

Though the Council does receive "a lot of complaints" the Council's representative noted that "not all are valid". Some may be in-fights or complaints people's neighbours who happen to be nurses for example. There are, however, "many serious complaints". The Council makes statistics available on its website and publishes some findings in the government gazette. The Council's representative indicated that as it stands "most complaints are about maternity" but that "there are also many complaints about basic nursing care". The Panel asked the Council to provide it with a summary of details of the complaints for the last five years.

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Jurisdiction and role of the Nursing Council

A member of the Council presenting on its behalf initially noted that the Council has "no jurisdiction to regulate private nurses". Questioned further about this by Chief Justice Ngcobo, the Council clarified that the problem was essentially not about jurisdiction but rather that the Council does not even know how many private practitioners are operating in South Africa or where they operate from. "We only discover problems when we receive complaints", she noted, adding that the nurses could be operating from anywhere – even a garage or Wendy house. Without "more information and regulations", she added, it is not possible for the Council to effectively monitor how nurses are practicing, for example to determine if nurses are using incorrect equipment or medication or are not properly licensed.

When questioned by the Chief Justice about whether the Nursing Act gave it jurisdiction over nurses in both the private and public sector, the Council representative clarified that what she was referring to is the fact that there are currently only draft regulations specifically governing private practitioners. They are therefore simply regulated like all other nurses. This, she noted has been the case since at least 2008 when the new Act was promulgated and the Department of Health has the responsibility to promulgate the draft regulations.

The Chief Justice then asked why it is that nurses operating in the private sector are not asked for the relevant information – such as where the nurse will be operating their practice – when they apply to the Nursing Council for registration.

The Council's representative answered that although the register is updated every year, it did not include this information. The Acting Registrar added that the Council is speaking to the Private Practitioners Association who does have a detailed list of its members which may be able to assist the Council. Though in the absence of a detailed register it could not be said exactly how many private nurses were working in South Africa she acknowledged that it is a "sizeable number". After more questioning the Registrar conceded that it was the Council's responsibility to complete the task of finding this information.

Shortage of nurses

Several panelists questioned the Council on the extreme shortages of nurses reported by participants in the inquiry consistently thus far. Initially, and curiously, the Acting Registrar denied that there was a shortage of nurses in South Africa. Later she explicitly retracted this statement saying "one would agree that there is a shortage of nurses", when pushed to do so by Professor Von Gent in particular.

This initial denial, however, led Chief Justice Ngcobo to ask directly whether it is not in the interests of the Council to ensure that nurses perform duties in circumstances in which they can fulfil their obligations. This question was intended to probe both the issue of shortages of nurses in both private and public hospitals but also the conditions under which they are forced to operate.

The Acting Registrar noted that the Council does bring the problems it uncovers to the attention of the employer in the case of a private hospital and the MEC or Minister of Health in the case of public hospital.

Later on, prompted by a suggestion from Chief Justice Ngcobo, the Council agreed that there are mostly shortages of nurses with specialisations and that certain specialisations are also the area in which "moonlighting" – public nurses working additional hours in private practice to supplement their income – is more prevalent.

Accreditation of facilities for nurse-training

The Council emphasised the importance of its role in accreditation of facilities that provide opportunities for the practical training of nurses. The Acting Registrar noted that the Nursing Council can assist in addressing shortages in a number of ways including the accreditation of sufficient facilities for training and fast-tracking of the accreditation of these clinical facilities.

Professor Fonn questioned the curriculum currently used to train nurses noting that it has been criticised for a range of reasons including that it is "old fashioned", does not consider health problems in South Africa, lacks context, does not sufficiently take into account healthcare legislation, and ultimately does not produce the kind of nurses that are needed in South Africa.

A third member of the the Council responded that the Council has made some strides in regards to curriculum review to deal with these criticisms. He noted that the curriculum review process requires consideration by both Nursing Council and the Council for Higher Education (CHE) in terms of legislation. The CHE's participation is to ensure that the curriculum meets academic standards. He therefore concluded that though he understood that to "the person on the street" it may look like there is an inordinate "delay" it is because of "these hurdles that have to be crossed before it becomes a curriculum".

Monitoring of conditions

The Panel took a specific interest in the Council's ability to monitoring the conditions under which nurses were forced to operate in the private sector. When asked by the Chief Justice whether the Council regularly monitors conditions, the Council's representative answered the Council is in the process of setting up an "inspectorate" to do so. However, at present, the Council only monitors conditions at a facility level when it receives specific complaints or when they are asked to accredit a facility as a place at which a nurse can do the practical component of their training. If the standards are "not conducive" accreditation is withheld. The Council is also working with the Office of Health Standards Compliance to improve upon this situation.

For clarification, the Chief Justice asked the Council to confirm whether it generally, in other words, has to wait for a complaint or "until somebody has been injured" before it can

investigate conditions at a facility. The Council's representative confirmed that this was the case because "that is the reality of the Nursing Act".

Nurses performing non-traditional functions

Section 56 of Nursing Act to allows certain nurses who are specifically qualified to perform functions that other nurses do not including to "assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions". Given the challenges faced by many people in South Africa in accessing healthcare the Panel showed a keen interest how this section, and the nursing profession, could assist in ensuring that the right to healthcare of each person in South Africa is made a reality.

Dr Bhengu, initiating this conversation, attempted to elicit comment from the Council on the non-traditional nursing roles that nurses can and have played in the effective implementation of South Africa's world-renowned antiretroviral programme. He asked specifically for comment on "where a change of the traditional role of nurses may help improve access to healthcare" more generally.

The Acting Registrar explained that the "Nurse Initiated Management of Treatment" is a process through which nurses were trained to initiate ARVs. The Nursing Council, she said, supported this initiative and it had a major impact on the treatment of HIV. She said that nurses qualify to initiate ARV treatment through short courses or programmes at present and that the Council is talking to the the Department of Health to see how this can be improved, perhaps by introducing a full year qualification that combines various short courses of this nature. When asked about an example about how a nurse's day-to-day job might be altered by taking on non-traditional functions, the Acting Registrar responded that, for example a nurse may be empowered to write scripts which could be taken to pharmacists to dispense medication. At present a nurse cannot write a script to be taken to a pharmacist and there are advanced discussions with the Pharmacy Council to try and empower nurses to do so.

A representative of the Council however noted that the Nursing Council does have some reservation about "task shifting" from other medical professionals to nurses because of the both the capacity of nurses and the increased risk that it would produce to both nurses and patients. Later on the Acting Registrar emphasised that there are some things the Council thinks that nurses can do and some that they will not be able to do.

Chief Justice Ngcobo, apparently unsatisfied with these responses, questioned whether the Nursing Council had engaged with the provisions of the Nursing Act that allowed nurses to perform other functions in certain circumstances. He emphasized that exercise of this power is the responsibility of the Nursing Council. He asked directly "What steps has the council taken to explore giving effect to these provisions to ensure that access to healthcare is at least accessible to the majority of people?"

The Acting Registrar replied that "there is a lot of work that has been done". She then gave more information interactions of the Nursing Council and the Medicines Control Council in this regard, assuring the Panel that "we hope within this year we will have moved quite a bit" toward the implementation of this aspect of the Act.

Concluding remarks

Ultimately, the Nursing Council indicated, that it is the Department of Health that is responsible for human resources planning, including for nursing professionals. It is therefore also responsible to address the shortage of nurses. A representative of the Council also noted that in her personal view nurses are not "paid enough for what they are doing. They are doing a big job and work long hours" and are not paid in accordance with a professional salary.

One of the major challenges noted throughout by the Acting Registrar is the turnaround time for the Nursing Council in addressing complaints and other issues. She explained that this could partially be attributed to the fact that the Council's systems are largely still manual. However, she assured the Panel that an "improvement plan" was instituted in 2015.

The Council thanked the Panel for the opportunity to make presentations and indicated that it had noted several issues that it had not properly considered raised by the Panel. The Chief Justice cautiously commented that it sometimes seemed as if the Nursing Council, as is the case with other Councils, "do wait for somebody to do something [or some other entity] before it reacts". He suggested that "sometimes it may be better for Council to take proactive measures in the interests of its members."

Radiologists ask panel for help on pricing

5 MAY 2016

The Health Market Inquiry panel has its work cut out to determine the true state of pricing in the private healthcare sector. This week's public hearings concluded with submissions from the Radiological Society of South Africa (RSSA) and Mediscor PBM. The RSSA put forward a view that radiologist are price takers, contrary to views advanced in earlier submissions while Mediscor PBM focused primarily on Prescribed Minimum Benefits. Public hearings continue on 17 May 2016 in Durban. Bankmed and Medscheme are expected to make oral submissions.

The RSSA's submission kicked off with a question from the Chair of the Panel, former Chief Justice Ngcobo who asked why the RSSA had not come forward to participate in the public hearings prior to being requested to do so by the Panel. The Executive Director of the RSSA, Dr Richard Tuft, responded that the hearings were voluntary and that at the time the society had nothing to add to its written submission. Dr Tuft led the presentation with inputs from Mr Martin Versfeld of Webber Wentzel Attorneys.

The RSSA was described as a professional association of radiologists in South Africa, Namibia and Zimbabwe comprising 805 members. In South Africa, 913 radiologists are registered with the Health Professions Council of South Africa. The primary concern of radiologists is the well being and health of patients through accurate and timeous diagnosis. Radiologists are specialist doctors whose proficiency is interpreting images such as x-rays, ultrasound, CT, MRI's and others. In response to a question put by the Panel, Dr Tuft explained that while it is expected that all doctors have a working understanding of reading scans, radiologists are trained and have a specialised knowledge in interpreting images and produce the definitive report on the results.

Radiologists pay rental space to the hospitals in which they practice and mostly rely on referrals form other health professionals. Dr Tuft made it clear that radiologists pay hospitals market rentals, which is unrelated to the turnover. This was in reply to a question which had previously been raised by Dr Bhengu regarding lease agreements between specialists and hospitals. Dr Bhengu sought to understand whether any perverse incentives exist in these agreements. Dr Tuft added that their members were not part of any multi-disciplinary practise groups as this heightened the risk of over referring. Also, that they have no ownership in hospitals nor do they share fees with any third parties.

Private Radiology in South Africa

Most radiologists are hospital-based because their work is largely generated by hospitals. At present there are 85 major radiology practices and there is usually one practice per hospital. Radiologists provide a 24 hour service to hospitals, emergency units and general practitioners, and there is no fee differentiation for after hour services. According to Dr Tuft, radiologists are price-takers and will often charge medical scheme rates because the schemes will often

reimburse the member directly if the radiologist charges more than the scheme rate, leaving it to the radiologist to collect the entire fee from the member. This is difficult because, unlike other practitioners, radiologists seldom see patients on an on-going basis.

Peer review process

The RSSA has exercised two peer review processes– one through Verirad and another with a major medical scheme. The purpose for the processes was to look at billing methodology and to look at the way radiologists are practising. Dr Tuft explained that in the review with the major medical scheme, 20 practises were identified for evaluation. Five radiologists assessed the billing profiles without any knowledge of the identities of practises involved. From this process, coding challenges were identified. During questioning from the Panel, the representatives of RSSA conceded that they could move to the next level of review to make the process more appropriate, as it is currently lacks sufficient interrogation to determine the correctness of norms.

Coding and Fees

Dr Tuft took the Panel through the coding and fee structure which radiologists have used since 1969, concluding with a brief mention of the 2010 High Court ruling which set aside the National Health Reference Price List. Since 2010, radiologists have conducted cost studies internally and apply the CPI increase to benchmark fees. He stated that they are looking to the Inquiry to provide avenues for collective bargaining.

Mr Martin Versfeld of Webber Wentzel Attorneys was on hand to address questions about the legal history of the National Health Reference Price List and other matters. Mr Versfeld was the attorney for HASA in the 2010 case that set aside the NHRPL. He suggested that since the Competition Commission rulings, the provider groupings cannot discuss what would and would not be appropriate to charge patients for health services, which has resulted in some fees that are too high and indeed some that are too low (with specific reference to GPs). He indicated that the health provider groupings, some of which are his clients, were never opposed to a NHRPL process in principle. The main contention was around the process undertaken. Mr Versfeld addressed the existing statutory framework, in particular section 90 of the National Health Act, which provides the Minister of Health with certain powers in respect of pricing of health services. Mr Versfeld, in answer to a question from Chief Justice Ngcobo about what such a process should entail, outlined the following:

- The drafting of regulations in terms of section 90 to create a framework for determining pricing of health services
- Guidelines to facilitate the process
- A timetable that sets out timeframes for the entire process
- Submissions on a zero based costing model

- Practice Studies
- A proposal on the basis of submissions and studies and other inputs
- An opportunity for the interrogation of the proposal
- An outcome which is effectively a non-binding tariff for each practice area

He concluded that all of the above should be a transparent and consultative process to enable the greatest possible buy-in from the stakeholders.

Response to Previous Submissions

Dr Tuft also wanted to respond to some of the statements which have been made during the course of the public hearings. In particular, RSSA wanted to correct and clarify the information which was presented by the National Department of Health (NDOH) and Prof Justus Apffelstaedt.

According to Dr Tuft, the data relating to the number of CT scanners used by the NDOH was incorrect. He added that CT and MRI scanners are basic tools for radiologists. The NDOH argued that this equipment was overused or misused by radiologists. However, the true numbers do not reflect such a trend, nor has this been picked up by the RSSA, which monitors the utilisation of all diagnostic tools. Outliers are investigated by the RSSA. While a practice might be an outlier, it is not necessarily a result of unethical conduct but could be a result of, for example, a practitioner serving an area with over burden of disease.

Panellist, Mr Van Gent asked about the instances where radiological tests where repeated as different levels within the hospital system. Dr Tuft suggested that radiologists communicate to patients what processes have been done and so it is unlikely that they would allow another doctor to re-do the tests unnecessarily. This is curious considering that one of the issues which have been brought to the Panel is that patients are not always aware how and for what they are charged.

Dr Tuft spoke to several issues that had been raised by breast surgeon, Professor Justus Apffelstaedt. Regarding the scope of practice and accreditation, Dr Tuft clarified that radiology specialists are trained and accredited by the HPCSA, and this is critical to ensure that users can be confident that they are being treated by a qualified professional. He said that the RSSA supports a multi-disciplinary approach made up of various specialists but that RSSA does not support other professionals conducting work outside of their scope of practice.

Finally Dr Tuft compared the fees charged by Professor Apffelstaedt in his cost study to Discovery's radiology benefit for 2016, suggesting that the surgeon's assertion that his fees were more affordable was incorrect.

The RSSA was questioned intently on possible perverse incentives and the assertion that radiologists are price takers. This was interesting because radiology has been cited in previous submissions as the one of the most expensive specialties. RSSA maintained that radiologists were price takers and that since 2004, no mechanisms have been available for collective negotiation to determine what a reasonable fee might look like.

Mediscor PBM

Mediscor PBM is a pharmaceutical benefit management company. Mediscor's presentation was led by its CEO, Mr Rademan, who began by comparing the company's function as akin to a credit card, which is presented for payment at a till, and payment is effected after a number of check have been done (available balance, security etc). Mediscor's system conducts hundreds of checks in a few seconds, happening in the background of a pharmacist's computer, before a medicine is dispensed and paid for by a medical scheme, with or without co-payments.

Mr Rademan described the company as independent from the medical schemes, administrators and all other stakeholders. The medical schemes, administrators, managed care organisations, health insurers and labour sick funds are its clients and it is itself an accredited managed care organisation.

Mediscor provides an electronic interface that operates between its clients and the pharmacy when a member is buying medicine at a pharmacy. It conducts the real time claims processing, designs the medicine formularies and protocols and adjudicates issues. The software is sophisticated and can handle multiple rules within each scheme, and picks up on clinical factors related to individual patients to avoid contra-indications.

The effect of the Mediscor's involvement in the market has been to encourage the use of generic medicines, which currently stands at 57% in South Africa. In comparison, Namibia has barely achieved 30% and Botswana is under 25%.

Prescribed Minimum Benefits

The Prescribed Minimum Benefits (PMBs) have been discussed a great deal during this hearing. Mr Rademan suggested that one of the negative consequences of the PMB framework is that it prevents to some extent the development of low cost benefit options. Presumably because a low cost scheme would have to offer the same cover as the current schemes.

The Panel sought to understand how the introduction of PMBs affected chronic conditions. Mediscor said that since the inception of PMBs, an increase in overall expenditure of chronic medicines has been observed, but was unable to comment on what that means in terms of health outcomes because of the nature of chronic conditions.

Role of Council for Medical Schemes (CMS)

The CMS currently retrospectively reviews the contracting arrangement of administrators and managed care organisations. Should the CMS have any concerns about the contracts, the conclusion of the contracts is delayed and can be subject to legal processes that are costly. Mr Rademan suggested a solution, which would require a change to the legal framework to allow for the CMS to review tender allocations for administration and managed care services prior to their finalisation. The suggestion was that greater oversight is needed by the CMS but also that such oversight would reduce the potential for legal processes, which are costly for the CMS.

Also relevant to the CMS and its jurisdiction, Mediscor complained that other managed care organisations bundle their services so that it becomes difficult to identify the layers of services so that the client can determine the value of the managed care component. In answer to a questions from Dr Bhengu about the influence of administrators, Mr Rademan said that Mediscor has lost their managed care business to the administrators. When pressed for an example, Mr Rademan said that it had lost two large clients when Discovery took over as the administrators.

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Make private health "more human"

19 MAY 2016

FDoH: "some of these things don't need regulation, they just need us to be more human"

Free State is a centrally located province within South Africa and is divided into one metro (Mangaung Metro) and four districts: Xhariep, Lejweleputswa, Thabo Mofutsanyane, and Fezile Dabi. From the outset the (FDoH) highlighted that the Free State is a predominantly rural province with a population of 2.6 million over the entire province.

The FDoH noted that Mediclinic dominates within the province in terms of the number of beds and that there are generally significantly more private hospitals in Free State's only major urban centre in the Manguang metro. There are districts within the Free State that have no private sector hospital beds at all.

The difference between "need" and "demand"

The FDoH explained that one of the challenges in a situation in which there is unequal distribution of private sector beds is encapsulated by the distinction between "need" and "demand", which are too often conflated.

Demand, the FDoH submitted is related to want which can be created whereas need is related to, amongst other things, burden of disease and availability of healthcare services. Demand for private healthcare is higher in Bloemfontein than anywhere else, with result that there is excess capacity in terms of beds. This happens at the same time as the need is high in poorer more rural areas, but the demand is lower because people are less able pay for private healthcare.

Hospital accreditation and licensing

The FDoH told the panel that this distinction between need and demand plays out with regard to applications for hospital licenses in different geographical regions because they "follow the markets".

In discussing hospital licences, the FDoH explained that a hospital group would need approval to begin building but then licensing in conformance with other standards once a hospital has already been built. This causes some issues including the fact that approval will be given then because of poor planning a hospital will just never be built even though the Department has factored it in its understanding of the availability of access to healthcare it would provide.

To remedy this problem, the FDoH now insists on accessing business plans for facilities before granting approval to build. This does help but the FDoH noted concerns about the poor quality of business plans and the difficulty in assessing them.

Even if a business plan is in order and approval is granted to build, the FDoH indicated that there are other problems that prevent hospitals from being built and opened.

One such problem is that there are often "huge delays" caused by municipalities in the process of purchasing land. It is possible that nothing happens for several years after approval is granted by the FDoH and "this means that people are not getting services they need because municipalities are not moving quickly enough". In reply to a question from the Chief Justice, the FDoH noted it had not properly engaged municipalities about this issue.

A second problem is that banks will sometimes cause obstructions in the process and "tamper with the need" for a facility that has been identified and approved by the FDoH. The FDoH gave an example of Standard Bank refusing funding for a facility providing "acute" services rather than "sub-acute" services because of its own independent studies on the financial viability of a facility. Businesses are then forced to change their business plans to accommodate what they can obtain funding for.

A final problem in this process of hospital licensing identified by the FDoH is that it has struggled with "quality assurance" with regard to private facilities. Because hospitals are assessed for licensing after already being built the FDoH has problems because some quality issues "cannot be reversed" after the building has been built. Information about the quality of private healthcare facilities

In addition, the FDoH conceded that information on quality is "kept within the department" and not made public which would allow the public to compare quality of different hospitals and hospital groups. The FDoH's representative was forthright, acknowledging "I want to make it clear that … we have come short" concluding "this is an oversight".

The Chief Justice questioned whether it was a problem that regulations did not require reporting on quality in private facilities as it did for public facilities. The FDoH accepted that this was the case and gave examples of positive instances where the FDoH had conducted "proper data collection" including the private sector in instances such as the Minister of Health's HIV Counselling and Testing (HCT) campaign and the publication of data on maternal mortality.

Problematic Private Public Partnership (PPP) with Netcare

In 2002 FDoH entered into a PPP with the Netcare Hospital Group that was supposed to last for 16 years and end in 2018. However, as a result of drawbacks in this process this period has moved four years and now the PPP will end in 2022. The FDoH explained that the purpose of the PPP was to provide shared services at two different hospitals: Universitas and Pelonomi hospitals. It was also hoped that the PPP would assist in revenue collection from fee paying patients and assist in the redirection of revenue collected to improving health outcomes in the public healthcare sector.

However, the FDoH's submissions revealed that because the PPP was "not succeeding" the FDoH engaged KPMG to audit the success of the programme. What was uncovered is that the risk burden lay with FDoH itself and that the revenue streams were not being channeled successfully. The FDoH's representative explained that the impression of some within in the FDoH is that Netcare primarily signed onto the PPP merely in order retain a license until 2022. Though there are serious concerns about the PPP, the FDoH noted that to leave it might have legal consequences or penalties.

Another concern with the PPP is small portion of the revenue acquired through it that accrues to the FDoH. As an example, the FDoH indicated "complications" resulting from the PPP with regard to radiology. The FDoH noted that although radiologists have told the panel that they are "price takers" in the Free State "we have a different experience". In terms of the PPP the FDoH is only entitled 33% of radiology revenue which comes to about R30 million of a total of 80-90 million received in the hospitals that are subject to this PPP. This is despite the fact that "all the risk is on us" because the FDoH owns the radiology equipment, maintains it and its employees are providing the services. Netcare, according to the FDoH does not have any of its own radiology capacity in the Free State. Practically all that happens now is that all of Netcare's patients are transferred to the state hospitals and seen in the public sector with most of the benefit accruing directly to radiologists and some to Netcare.

Remuneration for Work Outside the Public Sector (RWOPS)

The FDoH's representative explained that the private healthcare sector is driven by financial incentives and that if a healthcare professional is called by Netcare to do some private work, and they still have to see poor people in their capacity as public sector doctors, "we know where they are going to go". The FDoH reminded the Panel that this is even more distressing because in the environment of the Netcare PPP is using the state's equipment and premises. The health professional simply walks out of one room in the hospital where she is providing public sector services into another one in which she is performing private services.

The problem became so bad, according to the FDoH, that health professionals were leaving their posts during "peak hours" (10am – 2pm) to other rooms in the same hospital to do private work. This resulted in the "juniorisation" of the system – junior health professionals taking charge of tasks that should be led by seniors who were off doing private work – which ultimately had a poor effect on quality of services. The FDoH noted that this "juniorisation" led to "many" sets of litigation a junior professional made an error a senior might have avoided.

The FDoH said the biggest problems with RWOPS are at academic hospitals and with regard to "super specialists". There are even possibly problems with doctors who have academic, service training functions doing private work while they are supposed to be performing teaching functions.

The Chief Justice asked the FDoH whether the major problem with RWOPS was that they are generally difficult to monitor. The FDoH agreed that in principle there is no problem with RWOPS and the biggest issue does arise because there is not a good enough monitoring mechanism.

RWOP litigation

As a result of all of these problems in 2014, the FDoH determined that RWOPs would not be permitted between the hours of 7 30am and 4pm. This was an attempt to take a middle ground approach because the reality in the Free State would not allow for the absolute approach against RWOPS taken in KwaZulu-Natal.

Though this instruction is being reviewed by the Free State High Court – in a matter that will be heard in July this year – according to the FDoH it is still currently being implemented. In response to questioning from Dr Bhengu, the FDoH acknowledged that this litigation has caused a "toxic environment" in which the FDoH lost the services of approximately 50 specialists who left for the private sector, academic posts or on early retirement although "some are moving back towards the public sector".

In response to a question from the Chief Justice a representative from the FDoH in the legal services department explained that the basis for the review of the department's instruction with regard to RWOPS was not the concept of RWOPS in principle but the FDoH's alleged procedural failure to consult healthcare professionals in making this determination.

The FDoH was adamant that RWOPS are not a right but a privilege and although in the short term they need to be standardised in the long term legislation and regulations need to provide a "better strategy" to ensure specialists have everything they desire in the public sector and are paid enough to devote all their time to it.

Public Sector Dumping

The FDoH told that panel that the department frequently receives calls from private hospitals to say that because a patient's medical aid is exhausted she needs to be transferred to a public hospital.

They noted that there were other shocking examples where a baby and its mother were separated based on money. The mother was admitted and gave birth at a private hospital but because the baby required neonatal care not covered by the mother's medical aid the baby had to be transferred. The baby died. The FDoH asked "what happens when a patient is lying in ICU and runs out of funds? What is the medical aids responsibility?"

FDoH cited another example about a patient from Lesotho who was admitted to a Mediclinic hospital in Bloemfontein. The patient had a "drug reaction" and had to be transferred to an ICU. When the patient's medical aid ran out the hospital called the patient's family in Lesotho

to come and collect the patient and the "they ended up in my office for help". "We need to end this", added the FDoH's representative.

Emergency Medical Services

Equally jarring was the FDoH's description of current issues created or contributed to by the private sector in the Free State with regard to emergency medical services.

First, the FDoH explained that it is possible that private ambulances have been known to arrive at the scene of an accident and then only service patients or victims who are covered by medical: "sometimes they [private ambulances] do not touch patients or victims if they are not covered".

The FDoH's representative cited an example in which there was an accident near Bethlehem and the three people involved in the accident who were covered by medical aid were taken to a nearby Mediclinic while all other people involved were simply left to wait for a public ambulance. The same is true, he said, of patients with medical aids who run out of funds where private ambulances might even refuse to take them to a public hospital for a necessary transfer.

Second, according to the FDoH, private hospitals will not admit patients carried by public ambulances even in emergencies. As a result, he explained, a public ambulance could drive past two or three hospitals and it won't even try and stop "because they know that the patient is poor and will be rejected".

When asked by the Chief Justice about the private sector's attitude to individuals without cover in need of emergency services, the FDoH's representative repeated "they always check first for medical aid" even "at an accident scene".

Third, even when private ambulances do pick up patients without medical aid it is only to take them to public facilities even if there are nearer by private facilities. They do this, the FDoH explained, only because the Road Accident Fund will reimburse their transport costs. "Your destination [public or private] is determined by your ability to pay", he concluded.

Though acknowledging that these problems in emergency medical services are big in the Free State, the FDoH's representative noted that these problems are nationwide. He concluded that "some of these things don't need regulation, they just need us to be more human".

Limpopo Department of Health

Next, the Panel heard from the Limpopo Provincial Department Health, which was represented by the Acting Head of Department, Dr Peter Kgaphole who led the submission. Dr Kgaphole was accompanied by Dr Pinkoane, Mr Ramulayi, and advocate Ramothopho

Licensing

There are 5668 hospital beds in the public sector in Limpopo and 925 beds in the private sector, with the highest number of private beds being in Polokwane.

The provincial Department of Health in Limpopo considers the proposed number of personnel and locations when deliberating a license application for a private facility. Applications are scored based on this initial process and if approved are passed on to the infrastructure team within the Department. Following the consideration of the infrastructural development plans the next steps of the process are taken by the technical and adjudication committee before finally being brought to the office of the Head of the Department. The HOD approves or declines the application and communicates this decision in a letter to the applicant. If an application is rejected the reasons for the decision are not provided in the letter but can be communicated to the applicant through an appeal process. Dr Kgaphole emphasised that this letter does not constitute a license, but is merely permission to plan and erect, a license is eventually issued before a facility can operate. Also, applicants are directed to build under the regulations of the municipality at which the hospital will be located. Once a license is granted, it is valid for 12 months and is subject to renewal after this period.

Dr Kgaphole admitted that there are several cases where permission has lapsed because the applicants fail to develop the facility. One of the challenges experienced by the province and new entrants is the lack of specialists, and often they have to recruit from Gauteng. Often specialists from other areas come to underserved areas on a sessional basis, especially those who operate within a group practice and can therefore visit the area interchangeably.

Applicants, he said, often frivolously submit applications and have no clear understanding of the purpose for tendering an application. He added that most of the applicants lack an understanding of the Department of Health's policies and guideline and reiterated the concerns of other provinces that there is a deficit in application from districts which need private facilities.

Recently the Limpopo Health Department was approached by the Industrial Development Corporation, which asserted that they had been mandated by parliament to consider how they could support rural areas. The Department was hopeful that IDC would assist applicants who have permission to plan and erect, but were otherwise unable to secure funding. To date however, they are not aware of any applicants who have been funded by IDC.

In response to one of the recurring questions from the Panel relating to lapsed licenses, Dr Kgaphole explained that in the most part applicants lack the expertise and capital to develop and eventually operate private hospitals. Also, he expressed that instead some applicants use the permission letter to fraudulently extort money from potential funders and never develop the hospitals.

The license in the province is granted to operate and so aspirant entrants begin building before the license is conferred. The Department carries out inspections at the construction site to satisfy itself that the players are able to recruit the appropriate personnel and get equipment before presenting them with a license.

The Panel was also very interested in how the Department attended to the provinces challenge of attracting specialists. A few of the representatives from the Department provided examples of collaborative efforts undertaken to train and draw in specialists. The Department has started targeting medical schools and presently works together with the University of Cape Town to train specialists who will come back to work in the province. United Nations' volunteer doctors and doctors produced through the Cuban government cooperative program are allocated to rural areas which is useful to extend access.

The National Pathology Group

The National Pathology Group (NPG) consists of competitor pathologist groups and is part of the South African Medical Association as well as the South African Private Practitioners Forum. It has 295 members.

Dr Erasmus, the NPG's President, led the presentation and explained that pathology is a referral practice about diagnosis of diseases. Several doctors also made oral submissions to the panel, including a histopathologist and Medical microbiologist. They explained the kind of diagnoses they make and the interaction with the clinicians, whom they advise on diagnosis and course of treatment. The microbiologists in particular, also offer infection-control and antibiotic management in private hospital facilities together with a range of clinicians and hospital management. Pathologists detect life threatening diagnoses involving meningitis, septicaemia, rubella in pregnancy, hepatitis, resistant bacteria and communicate their results to the treating doctors to enable proper treatment.

Quality

The recurring theme of quality of health services arose during the oral submissions, in particular in the discussion on professional accreditation. According to Dr Erasmus, laboratory accreditation is voluntary and is conducted by the South African National Accreditation System (SANAS) on the basis of internationally recognised standards. Dr Erasmus claimed that no other medical profession does this. Over 90 percent of private pathology groups are accredited. The accreditation focuses on quality management systems and on technical aspects of the practice. When questioned by the Chief Justice, NPG stated that such accreditation does include patient satisfaction information. However, it was clear that the information gathered in the accreditation process is not available to the public in any understandable format and could not be used by a patient to decide on which lab visit for a particular pathology service.

The panel interrogated the role of SANAS and whether the accreditation process could be taken further to produce information that would indicate the quality of services at a particular

facility, so that patients could choose services on the basis of quality. This is an ongoing point of discussion in the inquiry.

Utilisation

In respect of utilisation, another common theme, NPG suggested that utilisation is driven by age and disease burden and stated that pathology cost increases are not out of line with general trends. In total, 5.1 percent of medical scheme gross contributions go to pathology services. Professor Fonn questioned the increasing cost of pathology services, which, according to the data presented, increases at a high rate even taking account of utilisation. She also questioned the reliance of the actuaries appointed by NPG on the Council for Medical Schemes data instead of their own members' data, which could be obtained directly from the members. The NPG's lawyer responded that the concern about breaches of competition law led to the reluctance by members to share the data, even with a third party. He noted that it is a very real risk for members and that complaints had been made to the Completion Commission in this regard.

Employment of doctors

The employment of doctors by private hospitals has been discussed by most practitioners during these public hearings. NPG believes that employment of doctors by hospitals is not appropriate because of the risk of commercial pressures that could lead to unethical behaviour on the part of pathologists. The Chief Justice, Dr van Gent, Dr Nkonki and Professor Fonn all questioned the NPG rigorously, particularly given that the pathologists practice in corporate groupings and are effectively employed by them, so what is the difference? Indeed, partners get paid salaries commensurate with the level of performance and as partners get an annual dividend. The answer, like with other practitioner groups, is that the practitioners' only concern is the clinical practice and not the commercial incentive. Employment by private hospitals could lead to the loss of control over their clinical performance, which would be driven by the profit motives of the hospitals rather than the ethical motives of the individual practitioner. This is difficult to reconcile in light of the way the profession is organised into corporate partnerships. Professor Fonn in particular questioned the notion that doctors are perfect human beings, with only the purest of motives.

Add on testing and stakeholder complaints

NPG responded to the comments made by other stakeholders concerning the tests done by pathology labs in the absence of requests from the doctors. Dr Erasmus explained that there are several good reasons for this. In some circumstances it would be irresponsible not to follow up with additional tests and in some situations, it would save patients the cost of additional visits to doctors. In other circumstances, the doctors order additional tests based on initial findings.

Dr Nkonki raised some complaints made by other stakeholders about the charging of specialist fees for tests conducted by medical technologists and specialists, or specialist fees

charged for results generated by computer with no interpretive report. The members of the NPG indicated that it was reasonable and common practice. Specialists set up the algorithms for testing, which take skill and experience, and therefore the charge is justified.

Transformation

Dr Bhengu asked if the NPG has role or responsibility in driving transformation in the sector. In answer, Dr Erasmus said that while the NPG might be aware of the BEE status of its members, the NPG has limited resources and effectively consists of himself and a personal assistant. It therefore does not have the capacity to monitor transformation or do anything about it. Having said that, member of the NPG do offer training space for the training of registrars on request by the National Health Laboratory Services.

Tariffs

On tariffs, NPG stated that it does not have a view as a group, but that members negotiate with the schemes individually. Dr Erasmus believes that regulation would be counterproductive in the long term. Indeed, he said, free market competition is far better.

NPG has Guide to Coding, which is a list of tests' Relative Value Unit but has no price attached to the tests. The rand value would be determined by each practice and medical scheme. The guide is available to the public.

Professor Fonn asked whether automation does not save costs and if new technology has become cheaper, why we see no transfer of the benefit of savings to patients. Dr Erasmus answered that in fact the savings are transmitted and comparing price increases per unit of service to clinical services, pathology is increasing at a lower rate. In other words, the increased efficiency has been passed to patient in the quality and variety of services available.

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Bonitas: Medical schemes are expensive

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In the final sitting of this general round of public hearings, the Panel heard from Improved Clinical Pathways Services, Bonitas Medical Fund and the Chiropractors Association of South Africa.

Bonitas: "we [medical schemes] are all expensive to be quite honest"

Bonitas's presentation to the Health Inquiry followed a now familiar pattern of engagements between the Panel and the Medical Schemes and Medical Scheme Administrators. Bonitas's presentation focused on the schemes own challenges and the Panel's questions urged Bonitas

to focus on health outcomes and access to information as is raised repeatedly by members of schemes.

As a Scheme originally founded in 1982, primarily for black civil servants, Bonitas told the Panel that it is not a scheme which is "truly representative of South Africa's demographic." Bonitas has also consistently seen a movement of members towards the Government Employees Medical Scheme (GEMS) which have now "stabilised". This despite the fact that approximately 10% of Bonitas's membership are government employees who Bonitas's representatives indicated they "anticipate" are ultimately likely to move to GEMS.

Doctor Bhengu asked Bonitas why, if the decrease in membership through departures to GEMS had stabilized, the information provided by Bonitas indicated that it had lost 42000 members in 2015. Bonitas's representative responded that this is an issue that Bonitas studies closely and that the likely reason is that people are no longer able to afford medical aid because they lose their employment or because of the prevailing economic climate. However, Bonitas's representatives later commenting on commonality between schemes, said that "we are all expensive to be quite honest".

Bonitas also indicated in response to a question that it has the intention to merge with Liberty Medical Scheme, which it considers, despite media reports indicating the contrary, to be in the best interest of its members. In a "consolidated industry [increased] bargaining power will make a huge difference going forward", Bonitas's representative said.

Prescribed Minimum Benefits (PMBs)

In Bonitas's presentation its representatives emphasised the difficulty that schemes face in being treated as mere payers of healthcare providers' invoices. Bonitas explained that there has been an increase of approximately 52% in the cost per year, per beneficiary in terms of PMB claims. It added that the proportion of PMB claims in hospitals had increased more rapidly than for services provided outside of hospitals.

The explanation Bonitas proffered for this was "upcoding" by healthcare professionals, because schemes must pay on invoice in full and that "the PMBs have made South Africans Hospicentric". The result is that "most of our members actually end up in hospital", which Bonitas's representative plainly admitted "is a problem". Some healthcare professionals, Bonitas's representative explained know that if they have a certain number of patients they can plan a holiday to Brazil because they understand that whatever they invoice will be paid because they have a "blank cheque".

Professor Fonn questioned Bonitas on these conclusions asking whether it is possible that instead representing an increase in the costs of PMBs, this could reflect "a learning" by Bonitas that it was obligated to pay PMBs in full or by patients that they are entitled to full payment for PMB conditions. Bonitas's response was that although this may be the case, the situation is "not sustainable" for medical schemes.

Fonn followed up by asking if it was possible that there it is a lack of innovation from medical schemes that was driving hospitalization. In response to this Bonitas's representative noted that funders like Bonitas have become "very defensive around PMBs" and agreed that funders should rather look at this situation as as opportunity to innovate and make services more affordable to patients.

Dr Nkonki noted that it would have been good to have heard more in Bonitas's presentation about patients difficulties in claiming for PMBs as had been described to the Panel throughout the Inquiry.

Managed care and "improved clinic pathway services"

Bonitas's representatives expressed strong support for managed care services as an important way of reducing costs, improving health outcomes and combatting hospicentrism. According to Bonitas, the managed care approach is less paternalistic and moves the healthcare approach from one which is "rules-based" to one which is "member-centric". Bonitas aims to prevent low claimers from becoming high claimers through this proactive approach.

This approach also gives medical an incentive to prevent scheme members from getting sick, according to Bonitas's representatives, who added that schemes "must empower members with health records and to be able to identify conditions". The effect will be both lower costs for the scheme and lower premiums for members. A managed care approach has already resulted in a reduction in claims for Bonitas of approximately half a billion rand as a result of managed care in 2015, Bonitas said.

The Chief Justice asked since Bonitas is one of the schemes that has embraced Improved Clinical Pathway Services (ICPS), what the value of those services are from Bonitas's perspective. Bonitas agreed within two weeks to provide the Panel with a report, including figures, about the benefits of ICPS.

Bonitas's investments and returns to members

The Chief Justice asked Bonitas what it is that happens with the profits that it makes as a scheme on its investments. In particular, he asked repeatedly whether Bonitas ever reduced premiums as a result of profits made on investments.

Bonitas responded that over the last few years it has resolved not to keep reserves that are as high as they used to (up to nearly 40%) and instead "pass on to the consumers" profits made on investments. Dividends and and contributions are therefore ultimately diverted back to members in order to either lessen increases in premiums are or "enrich the benefits" available on scheme options.

Unsatisfied, the Chief Justice asked pointedly whether to Bonitas's representatives the scheme had ever, after a year in which there were strong profits, happily informed members

that there would be a reduction in premiums instead of a mere lessening in the increase. Bonitas's representative answered that he was not aware of this ever having happened in Bonitas nor in the medical scheme industry in South Africa at all.

When asked a similar question again by Professor Fonn later on Bonitas's representative responded "the short answer is no". Professor Fonn then asked whether it doesn't worry Bonitas that members were compelled to just wait for increases "year in year out". Bonitas responded that it was a concern and that "the lack of alternatives is a big problem".

Fraud, Waste and Abuse

Bonitas also dedicated a portion of its presentation to instances of fraud, abuse and waste which it described as "the elephant in the room" in the private healthcare sector. Bonitas noted that it had assessed 1.4 billion rand of claims over 2 million claims events and identified that 72 million rand or five percent are lost to fraud, waste or abuse. This is below some industry estimates which go as high as 12 percent.

Instead of "harassing providers" or trying to catch them out Bonitas's representative indicated that it uses this information in a preventative manner in order to "dialogue" and "engage" with healthcare professionals. When asked by the Panel why this was Bonitas's approach, Bonitas's representative explained that the process of taking legal action or laying complaints through channels like the HPCSA could take several years and that dialoguing is often more productive in ending fraud, waste and abuse which is not always intentional and sometimes there is a good explanation.

Quality of healthcare provided by healthcare professionals

A somewhat related concern raised by Bonitas is the quality of services provided by many healthcare professionals.

In response to a question from Dr Bhengu, Bonitas explained that it has a network of over 6200 doctors that services it members. Bonitas does "upskilling" for doctors across the country each year in an attempt to train doctors to do "what they do best" – care for patients. Bonitas's representative noted that this is especially necessary to improve doctor's confidence in an environment in which there are a "huge number" of medical malpractice lawsuits.

Professor Fonn pushed Bonitas to explain how it measures the qualitative improvement of the outcomes through the upskilling of doctors. Bonitas responded that it does not do so effectively enough but it does try to allocate members with higher needs to professional who achieve higher scores in their assessments. In addition, Bonitas uses TV programmes and electronic and print media to inform members of where they can get the best interventions and healthcare services.

The Chief Justice followed up with a series of questions about why the scheme, though obliged to act in the interests of its members, does not provide them with clear information in its possession that a provider is not going to provide them with quality healthcare. "How is that possible?" he asked.

Bonitas's representatives conceded that this was "regrettable" but that there was a reluctance to "mark" doctors as "good" or "bad" especially when they may have received poor training. Bonitas does not want to get into "an ugly interaction with healthcare providers". Doctors, Bonitas said, also often found "innovative ways" around actions taken to eliminate poor quality care.

When pressed further by the Chief Justice about sacrificing members' ability to access quality care, another representative of Bonitas interjected to clarify that from a "philosophical point of view" the Chief Justice was correct but the concern was a "significant backlash" from healthcare professionals which may include litigation. He concluded that the problem requires "an industry-based solution" for healthcare providers to be "side-lined" if they are not producing results or are not doing so cost effectively.

Unions role in representing their members in the medical scheme environment

Professor Fonn indicated that there had been "rumours" about "kickbacks" being paid to unions by brokers in exchange for influence on appointments. Bonitas's representative indicated though he had heard such rumours "often".

Unions, he explained, had a "difficultly" with the Medical Schemes Act because they are not actively acknowledged as representing their membership for the purpose of medical schemes.

Unions would therefore, in his experience, "like to have a bigger say" in matters relating to their members negotiating membership in medical schemes. They want to be acknowledged "on the same level as the employer" and in the absence of such a mandate in terms of the Medical Schemes Act, the tendency is for the employer to "step forward" and arrange brokers and/or medical scheme membership on behalf of employees.

Conclusion

In response to a question Bonitas's representative indicated that Bonitas would be in favour of "low cost options" for members and prospective members because "there is a high demand" for these options. He added that Bonitas would support low cost options that included preventative and primary care and not only hospi-centric PMB cover.

Improved Clinical Pathways Services

Dr Grant Rex, the Managing Director of ICPS led the submission accompanied by Dr Monica Springfield.

ICPS describes itself as a pioneering standardised care pathway group, which employs evidence based processes to address cost and quality concerns in healthcare provision. The internet has made it possible for more information to be shared and faster between health care providers and as a result ICPS has reengineered and made improvements to the managed care process. ICPS was established three years ago in South Africa and currently has 45 participating surgeons across all the provinces.

ICPS presently focuses on knee and hip replacements because of the high volume of these surgeries. Their first client was Transmed, and Medscheme and Bonitas have also come on board. Dr Rex explained that initially medical schemes and administrators were hesitant to work with ICPS, concerned that their members would be further restricted to the particular surgeons within the ICPS network. He added that because independence is highly cherished in the private sector, they initially experienced resistance toward standardised pathways, but their processes could not be argued with at a scientific level.

Dr Rex and Dr Springfield told the Panel that ICPS monitors hospital bills to assess whether the clinical teams are sticking to guidelines, saying that adherence to the pathway is a key quality indicator.

Clinical Initiatives

The key cost drivers the group identified are theatre time, length of stay, level of care (ICU and high care utilisation), surgical consumables utilisation, drug utilisation, clinician cost, radiology and pathology cost. ICPS offers a global fee to the providers within their network. The fee covers the cost of a surgeon, anaesthetist, consumables, hospital care, management fees and a physiotherapist. Even though ICPS uses global pricing, they still get detailed bills which they can use for clinical quality data.

According to Dr Rex, in South Africa, anaesthetists will usually see a patient for the first time when they prepare to go into surgery, however within the ICPS network a patient is seen by an anaesthetist at least two weeks before they are booked to undergo a surgery. This is done so that the patient can be optimised for surgery. This is particularly important for knee and hip replacement patients, because this kind of surgery is largely not in an emergency and due to the patient age group the candidates often have other health conditions the clinicians should be aware of and can therefore manage before surgery.

Only once the patient has been optimised, which means their other conditions are well controlled, will ICPS authorise the operation. The pre-operative assessment looks at kidney function, haemoglobin, diabetes to determine whether a patient can be operated on. The patients are scored to establish how compromised they are before undergoing an operation, and those whose condition is deemed to be uncontrolled will be investigated and managed before they are booked for an operation. Dr Rex added that this scoring is used to as a predictor of postoperative mortality and may predict early failure of arthroplasty.

The pre-operative assessment is performed by anaesthetists in most case, but where one is not available a physician will step in. Dr Rex said that anaesthetists are best placed to do the assessment because they make the determination on what anaesthesia will work best. Further he stated that it is best practise across the world to conduct a pre-assessment, however there are structural reasons these evaluations are not discharged. Most anaesthetists work as individuals he told the Panel, and they are remunerated using time units which cover the time patients spend in the operating room. It is not financially viable to allocate time for pre-assessments for anaesthetists, unless one is part of a group practise and a member can be allocated to perform the assessments. He suggested that alternative reimbursement models should be used to incentivise doctors to take quality into account.

Unlike in the public sector where post-operative case reviews are conducted, in the private sector a retrospective review is non-existent. ICPS carries out adverse incident reporting to evaluate a patient after their operation so that clinicians can identify mistakes and improve quality. The patient also reports on their outcomes, measuring the level of pain, function and comfort before and after the operation.

Additionally, ICPS spoke about quality measures they take to ensure clinicians provide good services to patients such as looking at the re-admission rates of the clinicians in their networks.

Finally, ICPS asserted that their global fee reduces administrative costs, eliminates unbundling and multiple coding and improve efficiency. Even so there has been backlash against this fee system as clinicians have been threatened by their respective associations claiming that the global fee is a breach of the fee sharing prohibition envisaged in the Ethical Business Practise Policy of the Health Professions Council of South Africa. Dr Rex considers the global fee as fair because once a surgical procedure is standardised the cost associated should be similar between clinicians in any case. The global fixed fee is paid out of the hospital benefit of a medical scheme

ICPS's business model was not envisaged in the Regulations and the organisation currently does not fall under the jurisdiction of the HPCSA or Council for Medical Schemes. Dr Rex argued that ICPS is a managed care company and should fall under the CMS's purview, but currently does not because they do not take on enough risk to be covered by the regulatory framework. He concluded that although ICPS would be best fitted within the CMS framework, the rules regarding registration were too onerous and would have to be amended to cater to an entity of their nature.

Ends