National Department of Health

Competition Commission Inquiry into Private Healthcare Market

Minister of Health
Dr PA Motsoaledi, MP
11 March 2016
Overview

1. Guiding Principles & Vision
2. Evolution of Private Health Sector
3. History of Regulation
4. History of Tariff Setting
5. Market Response to the Absence Tariff
6. Effect of Private Market on Public Sector
7. Overview & Solutions
1. Guiding Principles & Vision
The preamble to the Constitution of the World Health Organisation reads:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

Adopted 19-22 July 1946 New York
Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

Declaration II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
Universal Health Coverage

• These responsibilities find expression in the goal of universal health coverage.

• The goal of universal health is to ensure that

  All people obtain the health services they need without suffering financial hardship when paying for them.

  (WHO Definition of universal health coverage)
The South African Constitution and Bill of Rights enshrines the right to healthcare. Section 27 of the Constitution provides that:

(1) Everyone has a right to have access to -
   (a) healthcare services, including reproductive health care…

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

(Act 108 of 1996)

The State has a clear obligation to ensure access to healthcare for all.
National Health Act

- The National Health Act gives effect to the constitutional right to access health care services, as well as government’s responsibilities in realising this right.
- The NHA provides for a **single national health system**, in order to provide the population of the Republic with the best possible health services with available resources.
- Additionally, it explicitly **encompasses both public and private providers of health**

(Act 61 of 2003)
The NDP provides a clear roadmap to guide health system restructuring towards the goal of better health for all and that in 2030:

“…There has been a significant shift in equity, efficiency, effectiveness and quality of healthcare provision. Universal coverage is available....”
Target 3.8

Achieve Universal Health Coverage including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

(Adopted at the United Nations General Assembly 25 September 2015)
Prior to 1994 the South African health system was fragmented and designed along racially discriminatory policies. There were 14 health departments (servicing 4 race groups, including the 10 Bantustans), fragmentation between levels of care, and a systematically unequal financing and delivery of services.

Within this inefficient, divided context, one system was highly resourced and designed to serve the white minority, while the other, for the black majority, was systematically under resourced.

The Constitution abolished this fragmented health care system with the vision to establish a single seamless healthcare system. Inadvertently a two tier healthcare system developed- public and private sector. The private sector developed in the absence of a clearly designed policy.
Inequality produces the following scenario

Source: McIntyre & Ataguba (2012)
Health Expenditure

• The World Health Organisation recommends that countries should spend at least 5% of GDP on health.

• South Africa currently spends 8.5% of GDP on health.

• The private sector spends 4.4% of GDP on health but only provides care to 16% of the population.

• The public sector spends 4.1% of GDP on health but provides care to the entire remaining 84% of the population.
At the 65th World Health Assembly, May 2012 Dr Margaret Chan, the Director General of the WHO, outlined seven structural problems faced by global health systems

1. Rising health care costs yet poor access to essential medicines, especially affordable generic products;
2. Emphasis on cure that leaves prevention by the wayside;
3. Costly private care for the privileged few, but second-rate care for everybody else;
4. Grossly inadequate numbers of staff, or the wrong mix of staff;
5. Weak or inappropriate information systems;
6. Weak regulatory control; and
7. Schemes for financing care that punish the poor.
Universal Coverage as a Solution

Dr Chan (2013) further indicated that universal coverage was the most appropriate means to address these problems:

“Universal health coverage is the single most powerful concept that public health has to offer.”

“It is a powerful social equalizer and the ultimate expression of fairness.”
Each country will be able to identify which of the seven challenges are found within their system.

Unfortunately, South Africa is faced with all seven of them.
The South African National Development Plan identifies two objectives that must be realised to overcome our challenges:

1. The quality of services in the public health system must be improved
2. The relative cost of private healthcare must be reduced
2. Evolution of Private Health Sector
Private hospitals were not always the highest expenditure items for medical schemes
Inflation-adj. ZAR PBPM 1974 - 1998
Individual Practitioners

![Graph showing the inflation-adjusted Rands pbpm for different professions over years from 1974 to 1998. The graph includes lines for General Practitioners, Medical Specialists, and Dental professionals.]

Centre for Actuarial Research. P Rama & H McLeod July 2001
Benefit expenditure: ZAR PBPM (1997-2007)
IS THIS EVOLUTION A COINCIDENCE?
Only 12.3% of private hospital beds were outside three main hospital groups by 2006...
Private hospital real cost trends

Real PBPM expenditure


Coincides with market concentration

Source: CMS Data
Growth in Return on Investment

Cost of debt

Return on Investment
Returns for SA Hospitals versus Global Hospitals

Figure 3: ROS Comparisons (against global hospital firms)

Source: Do hospital mergers lead to healthy profits A Felet. Et al.
• Three of the largest hospital groups in SA are listed on the stock exchange.

• Companies on the stock must consistently maximise profits in line with investor expectation.

• These principles are often in conflict with the ethical responsibility of service delivery in healthcare where the health of patients is primary irrespective of their ability to pay.
2012 Total Hospital and Physician Cost

Bypass Surgery, 2012 in GDP PPP US$

<table>
<thead>
<tr>
<th>Country</th>
<th>Cost</th>
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<tr>
<td>USA</td>
<td>$73,420</td>
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<td>Australia</td>
<td>$27,109</td>
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<td>New Zealand</td>
<td>$21,813</td>
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<td>France</td>
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<td>United Kingdom</td>
<td>$12,843</td>
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<td>Switzerland</td>
<td>$12,189</td>
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*International Federation of Health Plans: 2012 Comparative Price Report. Price in USD was recalculated into National Currency using exchange rate and on this basis PPP exchange rate into USD PPP was applied.*
2012 Total Hospital and Physician Cost

Angioplasty, 2012 in GDP PPP US$

- USA: $28,182
- South Africa: $22,357
- United Kingdom: $13,070
- Spain: $10,629
- France: $6,939
- Netherlands: $5,945
- New Zealand: $5,785
- Australia: $5,588
- Switzerland: $3,640

*International Federation of Health Plans: 2012 Comparative Price Report. Price in USD was recalculated into National Currency using exchange rate and on this GDP PPP exchange rate into USD PPP was applied.*
2012 Total Hospital and Physician Cost

Hip Replacement, 2012 in GDP PPP US$

- USA: $40,364
- South Africa: $25,556
- Chile: $18,786
- Australia: $17,440
- New Zealand: $11,876
- United Kingdom: $10,816
- Netherlands: $10,503
- France: $10,024
- Spain: $8,699
- Switzerland: $6,582

International Federation of Health Plans: 2012 Comparative Price Report. Price in USD was recalculated into National Currency using exchange rate and on this GDP PPP exchange rate into USD PPP was applied.
• Are the procedures so complex as to be this costly?
• What about the simplest procedures?
Medical Male Circumcision
– A simple Procedure

• CMS 2013 average claims show that Medical Male Circumcision (MCC) can be conducted by:
  – GPs for R 1 121
  – but hospitals charge R 7 130

• There is no clinical reason why MCC inputs should differ across the two settings.
• Hospitals compete to attract specialists’ patronage

• The interaction between hospitals and specialists results in
  – Increased market power for specialists
  – Supply induced demand, including the Medical Arms Race
The Medical Arms Race hypothesis describes the scenario where hospitals spend unnecessarily on cost-enhancing technologies in order to attract patients via specialist referrals.

E.g. South African private sector has high availability of CT scanners per population relative to even highly developed countries.
CT Scanner Availability

Computerised Tomography (CT), per million population

Source: Analysis of licensed South African diagnostic imaging equipment J. Kabongo et al. 2015
Does this high availability matter?
2012 Total Hospital and Physician Cost

Scanning and Imaging: CT Scan Abdomen, 2012 in GDP PPP US$

- South Africa: $783
- USA: $630
- Chile: $328
- Switzerland: $300
- New Zealand: $288
- Netherlands: $251
- France: $168
- United Kingdom: $159
- Spain: $133
- Canada: $100

*International Federation of Health Plans: 2012 Comparative Price Report. Price in USD was recalculated into National Currency using exchange rate and on this GDP PPP exchange rate into USD PPP was applied.*
2012 Total Hospital and Physician Cost

Scanning and Imaging: CT Scan Head 2012, in GDP PPP US$

USA: $566
North Africa: $498
Chile: $269
New Zealand: $256
Netherlands: $237
Switzerland: $225
France: $168
United Kingdom: $159
Spain: $134
Canada: $100

International Federation of Health Plans: 2012 Comparative Price Report. Price in USD was recalculated into National Currency using exchange rate and on this GDP PPP exchange rate into USD PPP was applied.
2012 Total Hospital and Physician Cost

CT Scan Pelvis 2012, in GDP PPP US$

- South Africa: $640
- USA: $567
- New Zealand: $288
- Netherlands: $241
- Chile: $233
- Switzerland: $225
- France: $168
- United Kingdom: $159
- Spain: $132

Source: Department of Health, Republic of South Africa
Cost of CT Scan, Abdomen:
Ratio of GHI (2012)
Cost of CT Scan Head: Ratio of GHI (2012)
Cost of CT Scan, Pelvis: Ratio of GHI (2012)
Cost of MRI Scan: Ratio of GHI (2012)
Supplier induced demand: 75% c-section rate in the private sector (2011-2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Price Normal Deliveries</th>
<th>Price Caesarean section</th>
<th>ALOS Normal Deliveries</th>
<th>ALOS Caesarean section</th>
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<td>2011</td>
<td>16,251</td>
<td>27,802</td>
<td>17,954</td>
<td>31,912</td>
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<td>2013</td>
<td>17,954</td>
<td>31,912</td>
<td>17,954</td>
<td>31,912</td>
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</tbody>
</table>

OECD
Large increases in hip and knee replacements (31% and 53%, respectively), 2011-13, compared with relatively small increases in emergency surgeries
Medical Aid Schemes

• With this onslaught of prices medical schemes responded, but only to protect themselves.
• Instead of tackling the source of the high prices, they moved to the weakest link in the chain. The victims are:
  – GENERAL PRACTITIONERS (Providing Primary Health Care)
  – PATIENTS (Because of information asymmetry)
GPs’ share reduces

- Medical Scheme Expenditure in 2010
- Total medical scheme spend on health – R84.7bn
- Hospitals – R31.1bn, **private R30.8bn** (10%), public R281 (2.6%).
- Specialists - R19bn
- Medicines - R14bn (5.6%)
- GPs - R6.2bn (9%)
- Dentist - R2.5bn (13.2%)
- Allied - R6.7bn (11.5%)
- Total non healthcare- R11.6bn (6.9%)
GPs’ share reduces

Table 1: Medical Scheme Total Healthcare Expenditure, as Reported by CMS for 2012/13

<table>
<thead>
<tr>
<th>Total Healthcare Expenditure</th>
<th>2012</th>
<th>2013</th>
<th>2013 % of total</th>
<th>% change</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>R’000</td>
<td>R’000</td>
<td></td>
<td></td>
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<tr>
<td>General practitioners</td>
<td>7 473 029</td>
<td>7 828 970</td>
<td>7.0</td>
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<td>Medical specialists</td>
<td>24 029 975</td>
<td>27 541 423</td>
<td>24.5</td>
<td>14.6</td>
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<tr>
<td>Dentists</td>
<td>2 784 492</td>
<td>2 944 748</td>
<td>2.6</td>
<td>5.8</td>
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<tr>
<td>Dental specialists</td>
<td>743 273</td>
<td>806 560</td>
<td>0.7</td>
<td>8.5</td>
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<tr>
<td>Support and allied health professionals</td>
<td>7 975 704</td>
<td>9 493 169</td>
<td>8.4</td>
<td>19.0</td>
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<tr>
<td>Total hospitals</td>
<td>37 916 879</td>
<td>39 763 247</td>
<td>35.3</td>
<td>4.9</td>
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<td>Total medicines</td>
<td>16 340 020</td>
<td>18 045 546</td>
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<td>10.4</td>
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<td>Other benefits</td>
<td>3 771 315</td>
<td>4 400 249</td>
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<td>Total managed care arrangements (out-of-hospital benefits)</td>
<td>2 227 741</td>
<td>1 657 064</td>
<td>1.5</td>
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<td>Ex gratia payments</td>
<td>72 509</td>
<td>60 798</td>
<td>0.1</td>
<td>-16.2</td>
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<td>Total benefits</td>
<td>103 334 937</td>
<td>112 541 775</td>
<td>100.0</td>
<td>8.9</td>
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</tbody>
</table>

*Source: CMS Annual Report 2012-2013, Annexure G
Patients hit with co-payments

Medical Scheme:
Member No:
Dependant:
Service Provider:
Date Of Birth:
Authorisation Reference: 

At your request we are able to provide an estimated amount that will be funded by your scheme for your treatment.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number</th>
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<th>Scheme Benefit</th>
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Totals: R19,100.03  R5,109.30  R13,990.73
Medical schemes’ desperate attempt to survive
Demand-Side Response

- Schemes must manage expenditure and claims risk in the face of unregulated prices
  - Restricting benefits to the PMBs & often biased towards hospital costs
  - Establishing designated service provider arrangements
  - Complex scheme rules that limit the ability of members to easily register claims
  - Administrative barriers to limit the ability of members to query non-payment
- Each medical scheme compiles its own list of scheme tariffs
- Confusing for patients, with wide variation in charges across providers.
High non-healthcare costs

Administration fees should be low in large schemes

Average open schemes

Bestmed
Resolution
Discovery
Medihelp
Hosmed
Fedhealth
Liberty
Keyhealth
GEMS
Other undesirable practices
Broker fees increase

...broker fees increased sharply up to 2005 but has declined slightly since then...

800% increase in five years
What regulatory mechanisms have been instituted in light of this context?
3. History of Regulation
History of Regulation

• Medical Schemes Act, No. 72 of 1967: run on the basis of solidarity: minimum benefits and community-rating.
• Amendment Act of 1988: Mutuality principles
• Amendment Act, No. 23 of 1993: Statutory minimum benefits and guaranteed payment for claims removed
• 1995 NHI Committee of Inquiry:
  • Medical Schemes Act, No. 131 of 1998: re-introduced prescribed minimum benefits and community-rating ending
• Jan 2000: PBMs introduced
• 2004- SEP & Dispensing
• 2010 : NHRPL Declared invalid
What are PMBs?

• In trying to protect the patients the Minister and CMS established PMBs.

• Definition: Prescribed Minimum Benefits (PMBs) is a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.

• However, this did not have the desired effect and instead there were serious unintended consequences of bringing in opportunism from providers.

• This opportunism subsequently raised medical inflation instead of affordability.
The Medical Schemes Task Team (est. in 1997) responsible for defining and costing minimum package of essential hospital care. Recommended that:

- Primary care, chronic, psychiatric, infectious disease should be provided by State, from tax revenue.
- 598 diagnosis-treatment pairs were allocated to discretion (or urgency). Effectiveness, and cost categories in order to facilitate the prioritization process. Interventions were then ranked according to various mixes.
- The final “core-package” excluded interventions that were ineffective, non-urgent, non-life-threatening conditions.

PMBs are not envisaged as hospital based services only.

- They can also be provided in an ambulatory setting, and schemes are obliged to pay in full for these services.
- The Medical Schemes Act does not restrict the setting in which relevant care should be provided and therefore should not be construed as preventing the delivery of PMBs in outpatient settings where this is clinically appropriate.
What impact has regulation had on expenditure distribution?
% of Total Benefits Paid

- GPs
- Specialists
- Pvt Hospitals
- Medicines

Source: CMS Annual Reports 1983-2014
NDOH Analysis
GPs as % of total benefits paid

- PMBs introduced
- NHRPL removed
- RAMS Tariffs no longer statutory
- Dispensing Fees Introduced


GPs

64
Specialists as % of total benefits paid

Impact of statutory
RAMS Tariffs

1. Dispensing Fees introduced
2. BHF tariffs deemed anti-competitive

RAMS Tariffs no longer statutory
PMBs introduced
NHRPL removed

0% 5% 10% 15% 20% 25%


Dispensing Fees introduced
BHF tariffs deemed anti-competitive
NHRPL removed

Specialists

Health
Department: Health
REPUBLIC OF SOUTH AFRICA
Private hospitals % of total benefits paid

Period of Market Concentration

- RAMS Tariffs no longer statutory
- Growth in Pvt. Hospital Beds
- CMS reports Private Hospitals separately
- PMBs introduced
- NHRPL removed
- SEP and Dispensing fees introduced

Data from 1983 to 2013
4. History of Tariff Setting
Reference Price List (RPL)

- **RAMS: (Board of Healthcare Funders, BHF):** legislative responsibility of negotiating service tariffs: Regulated maximum prices that providers could bill and were equivalent to the reimbursement levels (last published in 2003).

- **1994: process was abolished through amendments to Medical Schemes Act (1967).** RAMS negotiated ‘guideline prices’, with provider organisations. The ‘Recommended Scale of Benefits for Medical Practitioners’ aimed to assist medical schemes with embarking on their own price negotiations with providers.

- **SAMA: ‘Doctors’ Billing Manual’** competed with the RAMS reference prices, with fees that exceeded the RAMS guideline prices. Patients paid the difference between the reimbursed amount and the price charged. (last published in 2003)

- At the same time HASA received permission from the competition authorities publish a ‘Benchmark Guide to Fees for Medical Services’. SAMA published its last Benchmark Guide to Fees for Medical Services in 2003.
2004 Competition Commission ruling prohibited any collective negotiation of prices: Ruled that the centralised tariff schedules were set in a collusive manner, with anti-competitive outcomes.

This ruling did not take into consideration the effect of the practice, but only the form, relying on a per se prohibition provision, which doesn’t require any justification or the weighing of effects of the conduct in the market.

The consequence of the ruling required medical schemes/patients have to negotiate tariffs with individual healthcare providers.
National Health Reference Price List

- **2004-2006**: Council for Medical Schemes established the National Health Reference Price List (NHRPL) based on an agreed list of services and standardised coding environment.
  - Based on BHF tariff guide adjusted for CPI and some cost-based methodology improvements
  - Medical schemes could use the NHRPL to calculate their own reimbursement levels based on membership and affordability, usually a percentage of the NHRPL tariff.
  - Set reimbursement level with no connection to the billed price charged by providers.
  - This resulted in members being billed for the 'balance' between the NHRPL/reimbursement level and the billed prices.
  - In the absence of penalties for exceeding the NHRPL provider groups in positions of market power face no incentives to curb their fees.
NDOH assumes responsibility for the Reference Price List (RPL)

• **December 2006** NDoH published regulations relating to the process of determining RPL for comments, in terms of section 90(1)(u) and (v) of the National Health Act, including labour costs.

• **July 2007** the Minister promulgated Regulations Pertaining to the Obtainment of Information and the Processes of Determination and Publication of Reference Price List, GG 30110 under GNR681.

• **February 2008** the Director General Health published Notice 190 of 2008, calling for submissions from all stakeholders contemplated in Section 90(1)(v).
  – This regulation served to invite private hospitals, medical practitioners and medical schemes to submit information regarding the cost of running health services.
RPL: Methodological Disagreements

- Non-representative sample size in the cost survey
- Incorrect cost data submitted by practitioners – identified during verification exercise.
- Disagreement regarding acceptable occupancy rates.
- Disagreement regarding property valuation – replacement value
- Providers unwilling to consent to verification process
- Private hospitals unwilling to share detailed information regarding cost information
• **2009**: HASA, SAMA, and others lodged legal action against the Minister and the NDoH RPL.

• **North Gauteng Division of the High Court: 28 July 2010**: Ruled that the underlying regulations for determining the RPL were found to be invalid, due to the absence of consultations between the Minister of Health and the National Health Council.
Developments since 2010

• The HPCSA is empowered in terms of section 53 (3)(d) of the Health Professions Act to determine and publish normative fees
• 2012: HPCSA attempted to issue ‘Guideline Tariffs’ for the determination of fee norms by the medical and dental professional board using the CMS's NHRPL 2006 rates inflated by 46.66%.
• Various stakeholders objected to the proposal alleging that they had not been consulted and that the basis on which the prices were decided was arbitrary, flawed and possibly anticompetitive.
• The South African Private Practitioners Forum, which represents specialists, threatened to take the Health Professions Council of South Africa to court.
• A discussion document published inviting interested parties to participate in voluntary price negotiation.
• Reluctance to participate in the voluntary price negotiation proposal – specialists and private hospitals
5. Market Response to Absence of Tariff
Supply-Side Response

- PMB regulations require that the medical scheme pays the provider in full for PMB conditions.

- In the absence of tariff providers have used this provision to:
  - Price their services for PMBs higher than non-PMBs
  - Classify conditions as a PMBs when they are not
Specialist billed rates for PMBs

Court application filed (September 2011)  “At cost” ruling (November 2011)

Graph showing the average rate billed relative to tariff from 2011 to 2012, with a significant increase in 2011.
Perverse incentives: Up-coding

Bipolar Mood Disorder (BMD) a CDL condition, whereas depression is not. Over time, cases of depression decreasing in numbers, apparently substituted by cases of BMD.

**Scheme cost**

-Major Depression
- Bipolar Mood Disorder

Source: C Raath, Insight Actuaries and Consultants
Substitution effect between PMB and nonPMB coding for anaesthetist services

Source: C Raath, Insight Actuaries and Consultants
6. Effect of Private Market on Public Sector
Cream Skimming & Dumping

Private sector skims the healthy and wealthy and dumps the sick and poor.

Examples of the following:

– Patients are transferred to the public sector when their medical scheme benefits are exhausted.

– Patients with suspected infectious diseases are diverted to public sector.

– E.g. Ebola and TB
## Patient Dumping

<table>
<thead>
<tr>
<th>Patient</th>
<th>Condition</th>
<th>Reason given for shift to state</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Requires a full cardiac assessment and probably an angiogram</td>
<td>Medical Scheme did not authorise PMB procedure.</td>
</tr>
<tr>
<td>B.</td>
<td>Requires a full cardiac assessment, assessment of his pacemaker and replacement of pacemaker</td>
<td>Medical Scheme exhausted, patient referred to public sector.</td>
</tr>
<tr>
<td>C.</td>
<td>Recent heart attack treated as an emergency in private.</td>
<td>Patient can no longer afford private medical care. Transferred to the public sector.</td>
</tr>
</tbody>
</table>
Private sector always to the rescue?
The impression is often that the private sector comes to the rescue of the public sector, but this is not necessarily so.

The structure in the private sector does not encourage peer review or team-work because referral always comes with financial implications from one speciality to another. This opens room for many misdiagnoses. These misdiagnoses end up being picked up in the public sector. But this will never be reported anywhere.
Examples

• Quite often, patients are caught between the funder and providers and public facilities always come to their rescue.
  – E.g. Patient on health plan needing neurosurgery. Health plan, having promised to give unending cash (as long as you’re admitted) insisted they would only give 50k but the private hospital insisted they wanted 250k. Despite being on this hospital plan, the public sector had to come to the rescue.

• Even patients in emergency situations are turned away from private hospitals if they can’t produce cash, in direct contravention of Section 27, subsection 3 of the Bill of Rights.
  – E.g. Patient with head injury had to be rescued. Scan done in private sector, blood clot found but no treatment without 100k. Patient transferred to state.
The Workforce Auction

- The private sector currently has 80% of the specialists in the country treating 16% of the population. Denying the poor who have the GREATEST need access to care.
- The private sector competes with the public sector for limited human resources.
- It is able to offer higher salaries which draws health professionals away from the public sector.
- The public sector is forced to offer high salaries (which it can ill afford) to retain staff. (e.g. OSD), thereby reducing the resources available to deliver services.
• When bed occupancy increases private hospitals access additional nursing staff through nursing agencies.
• These agencies employ nurses who work full-time in the public sector.
• This results in nurses working double shifts and putting patients at risk.
• Academics leave teaching/training in pursuit of treating patients in private hospitals.
• The general narrative is that the public sector is collapsing but the previous examples show otherwise.

• Part of this narrative stems from a completely wrong definition of what health is.

• The people who propagate this narrative see health as limited to what happens inside a hospital. They see health as only clinical medicine with particular emphasis on hotel services.

• To put health in perspective you need to look at it holistically. That is, both population health, commonly referred to as public health and clinical medicine (which is what happens in hospitals).
In South Africa the people who are propagating this narrative of collapse are deliberately and sometimes conveniently ignoring the huge strides made in population health.

Let us examine the facts...
### Achievements of the Country:

#### Population Health

<table>
<thead>
<tr>
<th>Selected Outcomes</th>
<th>2009</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy (years)</td>
<td>57.1</td>
<td>62.9</td>
</tr>
<tr>
<td>&lt;5 mortality/1000 live births</td>
<td>56.0</td>
<td>39.0</td>
</tr>
<tr>
<td>Infant mortality/1000 live births</td>
<td>39.0</td>
<td>28.0</td>
</tr>
<tr>
<td>Neo-natal mortality/1000 live births</td>
<td>14.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Maternal mortality ratio/100 000 live births</td>
<td>281.0</td>
<td>155.0</td>
</tr>
</tbody>
</table>
In recent times the public health sector has achieved a number of milestones for which South Africa has been lauded by the international community. These include:

– 10 Years ago, only 400,000 people were on treatment for HIV. Now we have the largest HIV treatment programme in the world with 3.4 million people on treatment and 10 million people tested for HIV annually.

– The programme to prevent mother to child transmission of HIV has reduced the HIV transmission rate from 8% in 2008 to 1.5% in 2015. This is done by providing mothers with ARVs at 14 weeks of pregnancy in our health facilities:
  • Reduced HIV infections from 70,000 babies in 2004 to less than 7,000 babies today.
Achievements of the Country:

Population Health

• Progress has been made in the control of TB where our treatment success for drug sensitive TB has reached 82% (Was 67% in 2009).

• 60% of all people on isoniazid preventive therapy (IPT) in the world are in South Africa at 552 000 patients (WHO Global TB Report 2015).

• First country to introduce GENEXPERT and in 2015 50% of the global volume of all tests are done in South Africa.

• The rollout of new multi-drug resistant TB medicines (Bedaqualine): 63% of global patients on treatment are in South Africa.

• This achievement is internationally recognised, hence I’m travelling to New York to receive an honour together with the Minister of Health from Pakistan and Prof. Paul Farmer (Prof Infectious Diseases at Harvard) at USAID 2016 World TB Day celebration 17 March 2016.
Achievements of the Country:

Population Health

- First African country to introduce vaccines for pneumonia and diarrhea (rotavirus & pneumococcal) in 2009 which has had a significant impact on these childhood diseases;
  - 2008 – 2012: 56% decrease in the child deaths due to diarrhea and 70% reduction in hospital admissions due to pneumonia with and a 53% decline in deaths from pneumonia. (National Institute for Communicable Diseases)
- In 2014 the human papiloma virus (HPV) vaccine was introduced to prevent cervical cancer;
  - Each year since 2014 more than 360,000 9yr old girls are given two doses of the vaccine as part of the integrated school health programme.
  - We are the first country in Africa to have a national programme (which is fully funded by the national fiscus).
We are steadily decreasing maternal mortality, largely through our HIV programme

– In order to empower pregnant women with knowledge about pregnancy and how to raise infants we launched Momconnect.
– More than 807,000 pregnant women have received weekly messages from the Department;
– The system allows unsolicited reporting of complaints and complements – cumulatively we have received 744 complaints and 4639 compliments;
– Momconnect was awarded a prize for innovation from the African Association of Public Administration and Management
These can’t be examples of a collapsing system.
Sometimes the manner in which information is brought to the public creates a feeling of doom and gloom or the general narrative of collapse…
Kalafong's lack of ventilators means staff pick who will live

LIFE SAVER

A ventilator is a machine designed to mechanically move breathable air into and out of the lungs. It provides the mechanism required for a patient who is physically unable to breathe or breathing insufficiently.

A newly donated ventilator supporting a patient at the Kalafong trauma and emergency unit. The machine aids patients who need assistance in breathing.

PICTURE: THOBO MAPHONG

Department:
Health
REPUBLIC OF SOUTH AFRICA
NEWBORNs IN DANGER

Vital TB drug shortage means no vaccination

A SHADOW of death hangs precariously over newborn babies in Pretoria, after it was suggested that public health facilities were discharging them without giving the life-saving vaccination against the deadly tuberculous bacteria.

This, according to a city expert, amounted to sentencing the babies to death. Despite denials from the provincial government hospitals and clinics across the city yesterday, it was admitted that stocks of the lifesaving Bacillus Calmette-Guérin vaccine – commonly known as BCG – ran out more than two months ago.

The staff in the hospitals said that the majority of newborn babies had not been immunised since early September, and that they had struggled with their conscience as health providers when having to let the children go home without being vaccinated.

Most of them said the hospitals had been battling to preserve the last of their stock of the vaccine since they realised they would have none as far back as August.

The back of the children’s health status and the environment in which they came from informed a decision on whether or not they should be immunised, health workers said.

The crisis has resulted in mothers being advised to keep their small babies indoors and away from people and public areas to minimise their risks on contracting tuberculosis. “We were told not to take our babies to church or to the clinic, and to completely avoid having visitors,” said a mother from Pretoria West, who gave birth three weeks ago at Kalafong Hospital.

When her baby was born, she was informed of the shortage of the vaccine, after which the nurse advised her not to expose herself or the baby to risky situations.

BCG is administered within the first 24 hours of birth. The administration is in line with the inoculation measures recommended by the World Health Organisation for all countries highly endemic for tuberculosis.

It is produced at an international level and distributed to the continents and countries, and when the global market was hit by shortages of raw material, South Africa was among the nations hit badly.

Countrywide, shortages were experienced, resulting in the provincial health departments scrambling to ensure areas most at risk were not badly affected.

Health Minister Dr Aaron Motsoaledi has, meanwhile, been criticised for failing to ensure the situation did not result in a shortage of stock, especially in a country which was hard hit by tuberculosis.

In addition, experts predicted that the virus which cripples the health sector.

The crisis has since been alerted at national level, and there are no shortages of the vaccine. However, the problem is the distribution process in the province, knowledgeable stakeholders said.

But Gauteng Health Department spokesman Steve Mabona denied that there were shortages of the vaccine in the province.

He said various hospitals like Pretoria West could provide 2,000 doses of BCG.

A picture of a mother, taken through a window of her home, sitting on her bed as she holds her 3-week-old baby who is confined to the house due to the shortage of BCG vaccine in the city’s public.

Health

Department:
Health

REPUBLIC OF SOUTH AFRICA
What detractors are actually referring to are problems in individual health facilities that impact clinical medicine.

We ourselves have picked this up as far back as 2010 when we commissioned four companies to audit all of our health facilities – all 3 500 of them.

- HEALTH SYSTEMS TRUST (HST): management, coordination with provinces, data quality control.
- ARUP ENGINEERING: Provided project managers
- EXPONANT: Built environment specifications.
- HEALTH INFORMATION SYSTEMS PROGRAMME (HISP): Field workers, data capturing, database administration.

This process led to the concept of the IDEAL CLINIC.
An Ideal clinic is a health facility that possesses the following characteristics:

“It is a clinic that opens on time in the morning according to its set operating hours and does not close until the last patient has been assisted, even if it is beyond the normal closing hours. It is staffed by health care providers who treat people with dignity, and observe the Batho Pele principles of Access, Consultation, Courtesy, Information, Service Standards, Openness and Transparency, Redress and Value for Money……It is very clean, promotes hygiene, and takes all precautionary measures to prevent the spread of disease. It has reasonable waiting times and community members do not have to sacrifice their entire working day to seek health care. It provides a comprehensive package of good quality health services every day and community members do not have to return on different days for different services. It has the basic necessities available such as essential medicines. It refers people to higher levels of care timeously when this is required. It works together with the community it serves with diverse stakeholders, in promoting health and socio-economic development. Finally, community members would say an ideal clinic is one that we can be proud of, and call it ‘our own clinic’ rather than ‘a government clinic’ or a ‘state health facility’.”

Address by President Zuma at launch of Operation Phakisa 2: Ideal Clinic and Maintenance. Pretoria, 18 November 2014
In the final analysis the problems in the public sector can be traced to four main illnesses. We are focussing on these four to change the whole narrative.

1. **Human resources**
   - Appointments
   - Planning, development and management

2. **Financial management**

3. **Procurement & Supply Chain function**
   - Problems pertaining to stock management (pharmaceuticals, consumables, equipment, devices)
   - Delayed payment of suppliers with consequent delayed delivery.

4. **Infrastructure and maintenance/repairs of infrastructure**
These Big Four are in line with the findings of the Harvard Global Health Systems Unit which was assessing problems of health care in Africa, South-East Asia and Latin America.

- This review found problems stem from:
  - HR
  - Procurement
  - Supply chain
7. Overview & Solutions
The World Health Report of 2008 by WHO identifies three factors, which prevent progress and good outcomes within health systems globally:

- Hospicentricism (Largely curative)
- Fragmentation
- Uncontrolled commercialism

Again, just like the seven structural problems mentioned by Dr Margaret Chan, South Africa faces all three of these factors.
Is the Constitutional right to health care services as a basic right in conflict with the rights of business to provide shareholder values?
If current trends in Private Healthcare Expenditure continue, total expenditure by medical schemes will grow from R124b in 2014 to R514b by 2026.
### Projected Total Private Health Expenditure

<table>
<thead>
<tr>
<th>Rand Million</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>Annual Nominal Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total private sector health</td>
<td>130,196</td>
<td>141,835</td>
<td>155,689</td>
<td>166,735</td>
<td>177,873</td>
<td>189,082</td>
<td>200,210</td>
<td>7.40%</td>
</tr>
</tbody>
</table>

Projected to be R 200 Billion by 2017/18
Based on these observations, some so-called analysts/experts are preaching that NHI will be an unaffordable system. It is because they are basing their calculations on this model of uncontrolled commercialism as illustrated in the previous two slides.
The solution is the pooling of funds into a single fund to enable access to good quality, affordable health for the entire population, not for a select group of people; such a system must be dictated to by the health needs of the population and not by uncontrolled commercialism as it is at the moment.
Within such a system there needs to be a massive reorganisation of the health care system, as mentioned in paragraph 2 and chapter 6 of the White Paper on NHI.

The heartbeat of such a system will be Primary Health Care. That means a system based on promotion of health, prevention of diseases and the entry to the health system at the PHC level with upward referral with GPs, PHC practitioners and PHC facilities being gatekeepers.
Supply-Side Regulation

• Intervention in a market through regulation is justified when the absence of regulation would result in the market failing to achieve an efficient allocation of commodities.

• Additionally, where market fails to achieve outcomes in line with social justice, interventions may be justified.

• Section 27 of the Constitution places an obligation on the Minister to implement measures that would achieve the progressive realisation in accessing healthcare.

• Supply-side regulation would include regulation of price and reimbursement mechanisms, including alternative reimbursement mechanisms.
### International approaches to supply-side regulation

<table>
<thead>
<tr>
<th>Country</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland, Australia, Hungary</td>
<td>Unilateral central price regulation for fees/prices or capitation or salary.</td>
</tr>
<tr>
<td>Czech Republic, Iceland, Japan, Korea, Luxembourg, Netherlands, Norway, Austria, Belgium, France Greece</td>
<td>Negotiated fees/prices or salary at central level between third-party payers and/or government and providers, or other interested parties.</td>
</tr>
<tr>
<td>Switzerland, Germany</td>
<td>Reference prices established centrally and local negotiation determines prices.</td>
</tr>
<tr>
<td>Canada, New Zealand</td>
<td>Local price negotiation</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>Price negotiation per insurer group</td>
</tr>
<tr>
<td>Denmark, Italy, Portugal, Spain, Turkey, Finland, Ireland, Mexico, United Kingdom</td>
<td>Capitation or salary negotiated by interested parties at central level.</td>
</tr>
<tr>
<td>Sweden</td>
<td>Capitation or salary negotiated by interested parties at local level.</td>
</tr>
</tbody>
</table>
Impact of Regulation on Medicine Costs

- Introduction of SEP and Dispensing Fees

[Graph showing the impact of regulation on medicine costs from 1983 to 2013]
Move towards a fairer, more efficient health system for all South Africans; one based on the values of justice, fairness and social solidarity.