Competition Commission of South Africa

Market Inquiry into the matter of

Private Healthcare Sector

Hearing 4/Day 4

held at Cape Town International Convention Centre
Cape Town

on

11th of March 2016

Panel:
Justice Sandile Ngcobo
Drs Cornelis Van Gent
Dr Lungiswa Nkonki
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Date: 15th March 2016

Editor: Zolani Mabele
JUSTICE NGCOBO  If you let me know when you’re ready to kick off.

MS DA COSTA  Thank you, Chair, we are ready to start.

JUSTICE NGCOBO  Thank you so much, and may I take this opportunity to welcome you to this hearing four on the 4th day of our hearings. Today we’ll be listening to the presentation by Netcare. When you look at the slides the name that is prominently here is not an incorporated, so I almost say we’ll be listening to not this incorporated, but this a Netcare to the presentation, right?

MS DA COSTA  That is correct.

JUSTICE NGCOBO  I wonder, would you please place your name on the record and just indicate who is the leader of the panel and the members of your panel as well?

MS DA COSTA  Thank you, Chair. My name is Melanie Da Costa, I am the director of strategy and health policy for Netcare, and on behalf of Netcare I just want to thank the panel for the opportunity to engage with you, to present and speak with you. With me today I have on my left hand side Dr Dena Van Den Bergh. Dena is in charge of quality leadership at Netcare. Dena has had 26 years of experience in the hospital industry, her passion is quality, patient satisfaction and all of those wonderful topics you will to engage with today. Next to me is Mark Bishop. Mark is head of group
services and specifically within function includes the funders and procurements. To the right [indistinct 3.07]. He is very good at cobranding, to my right, David Unterhalter, and Barry Childs who is the co CEO of Insight Actuaries and Consultants.

JUSTICE NGCOBO Very well. Could you let us know how you’re going to structure the presentation in terms of who is going to deal with what aspect? [indistinct 3.07] I think.

MS DA COSTA Yes, thank you, Chair.

JUSTICE NGCOBO Very well. You can go ahead, ma’am.

MS DA COSTA Appreciate it. So just on reflecting on what it is that the panel has requested of us, so we understand that in the session you would just like some broader context. We understand that throughout the inquiry we will be delving in to the broader detail on the topics of the factors that restrict, prevent and distort competition, and also obviously the regulatory context.

You will appreciate that we have made some very comprehensive submissions and if you will, we are not going to be covering them today. We will be touching on the topics broadly but you will have an opportunity to engage with our expert witnesses in
the weeks to come, specifically on the topic of pricing, bargaining power, geographic analysis and concentration, profitability and regulation.

In terms of the presentation, Chair, between Mark and I we will be just looking at an overview of the Netcare operations. We will be touching on the interaction between stakeholders. We’re obviously cognisant of the fact that you had extensive presentations on that in the last two days so we will give you a brief overview on the topic. If you want to delve in to more detail, feel free to ask and we will do so.

We thought that we would cover some practical examples on how it is that you can increase access to affordable care, and in doing that giving you a context of some of the constraints from a regulatory perspective. We will be looking at global comparisons and benchmarking, and then we will be looking at some of the challenges that we face in the South African market.

Barry Childs will give you an overview of some of the regulatory issues around the Medical Scheme Act and how that has introduced some floor costs, it won’t take too long. Barry can also take any additional questions on the analysis that Insight has prepared over the last few years, if you have any such questions, Dena will touch on the topic of quality and the publication of that data and the initiatives in the industry to date.
Chair, you realise we do have a strong legal contingency with us. We are aware that you have had some questions in the context of regulation. I am not necessarily competent to answer those but if you do have any questions you would like to put to the legal team, they have availed themselves and you are welcome to.

JUSTICE NGCOBO Yes, thank you.

Ms Da Cost So just a quick overview on Netcare. Netcare has assets in Southern Africa, that is specifically South African and Lesotho, and for those of you that don’t know, we have effectively a 54% stake in the largest operator of private hospitals in the United Kingdom. It is called BMI Healthcare. In total we have 113 hospitals, approximately 13,206 hospital beds.

The collaboration between private and public is something that we hold very dear to us. It is within our DNA to innovate on the topic of access and affordability and that is why I share with you that in Southern Africa we have five private public partnerships.

In the United Kingdom we have had several over the years but we can share with you that as much as 40% of the patients we see within our private business in the United Kingdom is funded by the NHS.

So the Netcare business was started in 1996. I do think I can share with you that in the
context of doctor shareholding it is not Netcare’s policy to have doctor shareholding. In the assets in South Africa all of them are fully owned by Netcare with the exception of three legacy ones. These are small specifically day clinics. They contribute, it wouldn’t be more than 3% of our revenue, we might have doctor shareholdings in those three but other than that we have no doctor shareholdings or incentives and the likes.

In terms of concentration analysis, I know that that is another topic that has come up. We can share with you that in the hospitals where we earn 95 to 97% of our revenue, we have between three and five private competitors in the catchment area, something that Meg Geurin-Calvert can expand on when she meets with the panel in a few weeks next month.

So just in terms of how we engage with our stakeholders. I would like to hand over to Mark Bishop.

**MR BISHOP** Thank you Mel and the panel. I am going to try and limit my discussion to how we engage around the patient journey. I will try and limit my discussion to how we engage with the different stakeholders in our environment, specifically medical schemes, doctors and then the patient, but I am going to focus that around the patient journey and how we engage with those stakeholders, to ensure that the patient’s
journey is facilitated. That is specifically around, you have heard through the inquiry the concerns many patients have when they aren’t treated for hospitalisation or for anything else, where there’s concerns around, they are worried about being paid, will there costs be paid. That is role obviously that is critically important for us because we do not want to inconvenience either our patients or our other stakeholders, being the doctors and those medical schemes and how we go about engaging.

The relationship with schemes can be a fraught one. I liken it to the fact that we are playing a tug of war. We are at the opposite ends of the rope sometimes but the reality is both parties need that rope and it is critical for us to find agreement. So when we have adversarial relationships, they happen, they can be around negotiation time, they can be around specific incidents during a year, during a process, but the reality is that it is in all our interests to find agreeable solutions and I think we do, we work very well both with small and with large schemes.

As you have heard through the inquiry, we do negotiate on a national basis generally. That would be based with the main administrators and sometimes with schemes themselves directly.

I wouldn’t differentiate that there is much difference between a large scheme and a small scheme when it comes down to negotiation because they require the same thing.
They are looking for services that are of quality, they are looking for services at a price and they want to deal with a hospital that is able to deliver this.

Now, sometimes that can be more difficult by the fact that we have 57 hospitals, as described. Each one of those is an entity on their own that runs and deals with patients and sometimes that can be more difficult because you are trying to engage nationally through 57 hospitals, and sometimes some of the problems that we might experience across funders is because something happens at one site that isn’t addressed properly at the time and then that has to get escalated.

Our engagements with funders put those kinds of processes in place whereby, they would fund or managed care organisation or administrator, agent or representative of that patient would engage with us either firstly at hospital level, either at a regional level or a national level. We put those processes in place simply because we want to address and ensure that the patient’s journey is facilitated.

To that point it is critical to understand that hospitals don’t admit patients, doctors do. Doctors see these patients, bring these patients and then admit them to hospital. They do that on the line of when they consult with the patient, I know we have talked about elective or cold cases and then emergency cases, but specifically around elective cases,
the patient will go and see a specialist, the specialist will diagnose, will make a decision and will schedule an admission with the hospital.

Now, how is that going to be facilitated or what is our process? It will be a necessity for a patient to get an authorisation. Now, that, depending on the scheme rules, they have changed this over the years, they first tried to make that the responsibility of the provider, they passed that back to the member. The reality is it just simply has to be done. Our role is facilitating that for the patient. So although the patient might be responsible and sometimes does contact their medical scheme, they would also do that through us. The ideal process for that would be for the specialist from the time he is scheduling that admission is that patient arrives in our preadmission clinics, I think you have heard about those. Now, that can be both an admin process and a clinical process whereby the patient is assessed, we look at the patient, we inform them that there is no worry about cover.

Now, I want to go to the question of cover because I think that has received quite a bit of attention at the inquiry. You have heard of examples, I think both from the public and from other individuals, where they have had and their claims not paid for. Now, I think it is point of fact that this hasn’t happened for hospital events and that’s simply because we have agreements with medical schemes. We understand process, we
understand the authorisations.

An authorisation is a twofold thing. One it looks at is the patient covered in benefit and two, is this clinically necessary. Now, from the benefit perspective almost all hospital admissions are, be it whether they are PMBs and for the few cases where there are non-PMBs, there would be another hurdle to cross with the scheme because they would look at it from the perspective of is it covered by benefit. The simple reality is we do not have many cases where something is not paid for in a hospital, either in full or where we would be to engage with the scheme to give detail.

The authorisation is not as simple as the patient arrives, because the scheme and the administrator will have rules around the managed care that are provided to that patient, and that might be the requirement that the patient receives and goes for a second opinion. This is relevant for larger procedures. We have had instances where managed care organisations have applied for rules such that a person coming for a knee replacement with a BMI/body mass index over 35, that would be refused on the basis of the patient should lose weight first or should be properly immobilised beforehand, in other words physiotherapy is done prior to it.

Now, those all exist. Second opinions are often required. We would assist with that process and we do get involved with both the medical aid and the administrator or the
managed care organisation in those instances. Again the primary reason for that is obviously we would like to be paid and we would like to make certain that we do not inconvenience the patient who is sitting in front of us.

This thing goes further because you have heard about networks and where schemes have restrictions, restricted options. Now, we have engaged and we contract with schemes either on a national basis or we’re included in to their DSP arrangements or we are excluded from those arrangements and that does happen in areas.

I have heard the inquiry talk about cases where patients can be made to travel 100 kilometres. Well that would be a failure of that system. The rules are quite clear and CMS enforces this about maximum radiuses from a network hospital, and my experience is that managed care organisations take this very seriously. I have not got any examples where a patient would be expected to travel further than what is convenient, and I think it is fair to say, that the regulations require that it is reasonable access, and reasonable access to a person with a motor vehicle is very different to that of one who does not possess such and has to rely on be it public transport or anything else. My experience is the managed care organisations understand that and manage that and put that together.
Now, that goes a little bit further because it asks the questions around who is included in DSPs and who isn’t. I think it is quite clear that at times we are excluded. We are excluded in areas where we would then anticipate that we could be in and I put it that way because you sometimes think you are the leading hospital in an area but leading hospitals are quite often excluded.

I would go further and say there are instances where centres of excellence might exist and you will find that those are often left off DSPs too, and they have done that on the basis of the agreement that they establish with the group or the hospitals that are included in those networks.

Now, that has been a major improvement in affordability because our differentiation across tariffs looks at two things, it looks at does it increase access, does it improve access to the public generally, and we do differentiate our tariffs on that basis, whereby certain funds, as you know, will have many options and I know some of the questions have been, do we need as many options as we have, but the reality is that the advent of low income plans and options have improved access dramatically. They have done that on a twofold basis, they have allowed the schemes to differentiate, it is the only time they can differentiate premiums for patients based on the patient’s income. Now, the schemes have taken that even further and looked to us as providers to discount our
prices to those and that has been something we have been willing to do. Those networks are a fundamental basis by which schemes are able to bring about bargaining power, and I would raise this point that, for instance, Keycare, which is an option in Discovery Health in its own right would be the third largest medical scheme in the country, that is one option on Discovery which would be the third largest scheme in the country and it is a network option, a restricted network option and a network option, for instance, that Netcare did not participate in for many years, and we have a limited number of hospitals on that, but it is a critical part to us and it is important to us from a perspective of volume. Those are some of the terms and means by which we engage.

Going to the issue around the patient’s journey, I explained the requirements around authorisation and what is necessary. Those deal with things around both the reimbursement and the means that we go about it. We also engage with schemes on a constant basis whilst the patient is in hospital, for instance, we differentiate between what is a predictable case, i.e. somebody who comes in, authorisation is for a hysterectomy, the anticipated length of stay is four days. We would engage with the scheme where that would be authorised and the patient might leave our hospital within four days and there would be no other communication with the scheme. We have duties to that patient however, and if that patient complicates, if there is a reason for that patient to go to ICU which wouldn’t have been planned, we would engage with the
medical aid organisation and the managed care organisation in order to ensure that that authorisation is either extended or its level of care is changed. Again, just to point out that level of care, both treatments etc. is not just the responsibility of the hospital, it is obviously of the treating doctor. However, we provide that information and it is important for us both, again, for reimbursement purposes, but also to make certain we don’t inconvenience a patient that we have engaged on that level.

What information do we provide on our accounts? I think you saw a very good example yesterday about what’s included. We show the wards, we show each line and item of code. I think though what wasn’t noticed is that in South Africa we give an unusual amount of information on our accounts. In most other countries in the world, items are rolled up, be it medicines or be they consumables. Even in a fee for service environment, there will be single lines for some of these items where they are done.

Our engagement with schemes as I have said is ongoing, annual for negotiations but we also meet at a very senior level with them on a quarterly basis. We meet with and scheme that wants to see us, be it an administrator or be it small or large. There are a number of, as you have heard, self-managed schemes, self-administered schemes, we engage with those too and we treat them with the same level of respect we need to because they are customers, they bring patients, they pay for patients. We need to deal
with them on that basis.

Then from the perspective of how we facilitate with the doctors would be around issues, and I make the point, we do not admit patients, doctors do. Patients are, if we want to use an 80/20 but the reality is it is more than 80% of patients are admitted on an elective or a cold case basis where they have seen a specialist in a room, they have been diagnosed and they are sent to a hospital, or they are scheduled for admission. Those ones are the simpler ones. The more difficult are those that do come through the emergency. There is an argument to say that most medical admissions by their nature would be emergency, but quite often those two are facilitated through an admission either by the specialist or a GP through a specialist, a treating physician in a hospital.

The emergency departments I know have come in for a bit of question around this and we appreciate that it can be confusing, but it is mainly confusing because of the anxiety that a patient has when they present, particularly in a state of true emergency at a hospital.

I think in one of the very first hearings, a Professor Herbst who is a nursing professional himself described his experience and his confusion, which, I would say, is drawn by the fact that you are arriving as, in his words, I was anxious, I was having heart pains and I didn’t know what to expect. That is incredibly difficult because you
arrive at a hospital and you believe that the hospital is treating you and the hospital is, because that is its facility. However the doctor who sees you, the professional is not employed by the hospital and in the emergency room that is fraught with problems. We believe it would be much better if that was something controlled by the hospital or employed by the hospital. It would enable that process so much better.

**JUSTICE NGCOBO** At some point just flag that, I would like you to say more about that because it does seem, I am not too sure what difference it does make though, the fact that the doctor operates from your hospital and the fact that the doctor is employed by you in terms of the quality of the care.

**MR BISHOP** Thank you, Chair. I certainly will, if I can just add marginally to this and I know my colleagues will bring this to your attention, too, it would allow, and I think some of the points are the doctors there fully trained, are they young locums. The reality is, we have excellent service level agreements with the practices that run in a hospital, and we mange those very tightly. I think the difference comes down to the fact that there is a lack of understanding around the number of accounts you might receive because the professional is going to bill for you as well as the facility is going to bill for what takes place. Then in addition, if pathology or radiology is performed
there are separate accounts.

**JUSTICE NGCOBO** You’re not suggesting by any means that you have no control whatsoever over the conduct of those doctors who operate from your facilities, in other words they can do whatever they like to do.

**MR BISHOP** Chair, not at all. What I am saying is we have very detailed service level agreements for those emergency room doctors and we manage those incredibly tightly. That service agreement will be followed up by our executive in charge of trauma and emergency. Any failures of that system would be reported and later we will talk about our patient experience forms where we track this and we have specific ones for the emergency room, and we would deal with those. It is not, I can remember at least three occasions where we have given notice to the practice running that and we have appointed another, simply on the basis where you are not happy with the patient experience and number of negative experiences that might occur. Those happen and we manage that very tightly, specifically when it comes in that emergency room department.

What I am saying, though, is that by including all of this in one thing, it would make one account which would sometimes simplify this for the patient, because as much as
we can try and give you that information, sometimes you are not ready to read a sign when you walk in and you are having chest pains. That would be part of the reason.

Just to add further, we don’t engage in the choice of treatment that the patient receives. That is the doctors to your point. We are not going to be able to change the quality delivered by that doctor but we do monitor it, for a case there are issues later and we need to deal with it.

Just as a note, doctors do not participate in any hospital revenue. They bring patients to a hospital, yes, but their only earnings come from their own billings and fees. There is no incentives, there is no participation, you have heard from Melanie that there is no shareholdings in Netcare and that applies to all professionals.

Next, just talk to the patient relationships and where we do it. One of the keys for us is around giving information to patients. We appreciate that this can be a difficult process for a patient. They are worried, they are concerned and one of the big worries is sometimes, will this be paid, and we have all heard nightmare stories, and it is anecdotal I am afraid, because there is really little evidence to say that this happens for hospitals, where I was stuck with a very large bill at the end of a hospitalisation event, and that is because the process is managed. It is clearly understood and it is managed by managed care organisations very well, but there is many ways that we try and give
this information to patients, both by the pre-admission clinic when the specialist directs to them prior to it, and where we inform them, where they can go on to our website, where there is details around emergency departments, how they work, there is information for private patients, there is information around the services that are covered and the specialists that are in those hospitals, and then we give substantive information on the admission and discharge process and details the kinds of treatment.

Further, and I know we have provided this to the panel and I trust that you have seen them, we give very detailed pamphlets about the top 50 procedures, about what to expect, what to anticipate, how you should prepare for this, should you exercise what to expect after you have been hospitalised, your recovery time and it continues.

In addition, information will be given by the nurses in the ward around wound care that they anticipate during and after the surgery, if that is going to be handled, what they should be expecting around pain management and how to ask for help. That is a big part of it. We encourage our patients to give us feedback both during the stay and after the stay.

To that end it is around measuring that patient experience. Netcare has followed a, and we talk about a multimodal system to do this, there are many ways, both whilst the patient is in hospital seeking feedback, there is a survey to be completed and somebody
will arrive before discharge with an iPad where in front of the patient they are asked questions and this is based on nine different topics, 21 patient perspectives are requested and this is part of an international system, HCAHPS, which is used in the United States, and Dr Dena Van den Bergh is going to detail that a lot more extensively and better than I can later. It is a critical part about how we evaluate both the performance at that hospital, that hospital manager, the nursing staff and that feedback is used constantly in order to improve.

Thank you, Chair.

JUSTICE NGCOBO Thank you.

MS DA COSTA Chair, I am just going to share a little bit more information about how Netcare engages its communities. It will give you a better sense of who we are. It won’t take very long but I think you will get a sense of some of the broader issues of concern.

So in terms of investment we have invested about R8 billion over the last eight years.

Last year that was ratcheted up to about R2 billion. Our Capex budget for this year is also approximately that amount.
The mainstay of our hospital business was put together in the 1990’s and early 2000’s. Since then we have only purchased one small facility, it does not even contribute 0.1% of revenue, it is that small, the Ceres Hospital, and we have expanded, specifically over the last few years as we have started seeing some bottlenecks within our network.

The first facility we opened over the last few years was the Netcare Waterfall Hospital. That was opened in 2012. In truth, we would have preferred to expand the Sunninghill Hospital because we had a lot of bottlenecks there but we couldn’t get the licences and after several attempts to do that, we purchased a parcel of land not too far away and we opened up Waterfall.

The demand for the service is such that we have had to expand the facility since. I know that you have had some questions about the impact of new hospitals in certain areas, does it drive up demand, doesn’t it, I can certainly tell you we have had no concerns from funders with respect to the Waterfall Hospital.

I am going to ignore Lesotho just for a second because I am going to touch on that as an example of some practical solutions in a little while. In 2015 I can share with you that we opened up a facility in Polokwane, a 200 bed hospital and one in Pinehaven. We didn’t get any push back from medical schemes on these new facilities, Polokwane, I think it was one operator in that area so it increased competition in the area. You will
appreciate that the cost of a new hospital is very expensive, we are talking anywhere from R500 million to a billion so the decision to open up a new facility is not taken lightly. We have a fincom which is a subcommittee of the Netcare board and once it is approved by the fincom it is obviously escalated then to the board for a reflection on whether that level of investment is warranted, what the local supply and demand dynamics might be and the shorter term versus the longer term opportunities of these broader areas.

Now, the single most important issue relating to access in South Africa is that of healthcare professionals. So the question is what does Netcare do in the context of assisting in the topic of healthcare professionals? We have five nursing colleges. From the outset of Netcare’s training history we have trained 40,000 nurses. The graduation pull every year is approximately three to three and a half thousand nurses per year. We graduate approximately 30% if not just slightly over 30% of total nurses from the private sector and about 20% at a national level.

There was a time not too long ago when quite a few of the public nursing schools were still closed and at that time Netcare was the largest educator of nurses in the country, and for your interest, the bulk of those nurses are for the broader public and not
retained by Netcare.

Netcare would love to participate in the education of medical doctors. You are going to hear throughout the presentation that there are many restrictions to this effect but I can share with you that notwithstanding, we do pay the public sector salaries of quite a few registrars and fellows. We have memorandums of understanding and cooperation agreements with six universities, to this effect.

Yesterday there were some discussions around transformation which is obviously a critical issue and something that Netcare has as one of its strategic pillars. We have the Hamilton Naki Clinical Scholarship Scheme. Effectively we look at specialists of the highest of calibres coming from previously disadvantaged backgrounds that would like to do post-doctoral training. We give them an opportunity to continue training at any university in the world for an additional three years and our desire there is to make a difference to academic healthcare in South Africa. We obviously have a condition that they come back to South Africa and contribute. So the intention there is to revitalise clinical research in South Africa.

So the slide you have before you is just what do we invest in corporate social investment. We spent about a quarter of a billion rand over the last few years. You can see the bulk of this graph is indigent patients and what that means is, whether you
have been picked up at the side of the road or whether you present to an emergency department, this is the bills that are written off on these patients.

We have a whole lot of other initiatives and if you may I will just quickly touch on those.

JUSTICE NGCOBO Could you just go back to the previous slides, the very last item, public sector strike?

MS DA COSTA Certainly, sir. So, Chair, this public sector strike occurred in 2010. Does that ring a bell?

JUSTICE NGCOBO Yes.

MS DA COSTA So Netcare was made aware of some specific problems around the Gauteng region, specifically the Natalspruit Hospital, and we went in and provided the evacuation. Initially our thought is that it was going to be a ward of 24 babies. It turned out to be significantly bigger, but the moral to the story is, we ensured that there was capacity in one of our close by hospitals, Garden City Hospital, and we played an active role through Netcare 911 in evacuating patients and moving them to the public sector and just trying to keep the status quo while the public sector strike was ongoing.
It obviously played out for a little while. In the end we treated 600 adults and about 217 babies through that strike.

So I think the indigent patient treatment is probably well understood. Looking to the panel I don’t think I need to elaborate on that, but to give you another sense of some of the activities that we partake in. As you well know, South Africa has a very high record of sexual violence. In the period of 98 through to 2000 we were recorded as the country with the highest rate per capita in the world.

At this time South Africa learnt or Netcare learnt a very valuable lesson. We had a very prominent journalist appear in one of our clinics or one of our hospitals and we did not give her the treatment that she deserved or required at the time. So our CEO took it upon himself to never have this happen in one of our hospitals again and we set up 37 sexual assault clinics. This is basically in our emergency department. It gives a lady an opportunity to come in, take a shower, have a change of clothes, get in a counsellor, do the appropriate rape crisis kits and just for the record we have helped to get a very high conviction rate on these cases, give ARVs, deal with the follow ups, etc. etc. We have had 11,000 such cases to date since these assault clinics were set up.

On a more positive note, we have the Hear For Life programme which is the gift of
hearing, we have the Netcare Sight For Life programme which is the gift of sight and we have the cleft lip palate which is obviously the gift of a smile.

In terms of Walter Sisulu it is a pretty well known cardiac paediatric foundation. It has had the blessing of looking after a good 500 babies across the continent and that is the gift of life. If you haven’t been to that ward it is absolutely worth going to that ward.

I think that covers it from this perspective but I think what we wanted to share with you is that whatever the need in South Africa is, be it a strike, be it a Cholera break out, be is Ebola, be it Marikana, Netcare is always ready to act.

So, Chair, we understand that the panel is interested in understanding ways in which one can reduce costs and increase access, and there has been a lot of theory/anecdotes spoken about over the last few weeks and we thought that we could give you two practical examples that share with you how this might play out and if you will bear with me through these examples, you will actually understand some of the constraints we face in South Africa that impede affordability at times, or efficiencies.

So you have, as you can see on the slides, you have a reflection of Netcare next to the NHS, which is the United Kingdom Healthcare Provider, and on the other side you have a picture of the operations in Lesotho. So in debating this, I thought I could just
put up what we have done in the NHS, the problem with that is the NHS spends 2.5 trillion rand on healthcare. That is obviously significantly more, our population sizes aren’t too different. Lesotho, on the other hand, has 10% of the NHS expenditure per capita and from a per capita perspective we can relate better to Lesotho. So I thought that we would start off with Lesotho, if we may.

JUSTICE NGCOBO  The picture on the extreme right, if you go back to the previous one, that picture on the extreme right doesn’t illustrate the extent of your cooperation, does it?

MS DA COSTA  Sir, I am trying to see you right and my right. So you are talking the Queen Elizabeth the 2\textsuperscript{nd}. The middle one.

JUSTICE NGCOBO  That floor with broken tiles.

MS DA COSTA  No, the hospital with the pothole, no. That is the old Queen Elizabeth the 2\textsuperscript{nd} facility that was replaced in Lesotho. The picture that you have next to it is the new facility. Do you feel better?

JUSTICE NGCOBO  I understand.

MS DA COSTA  Super, thank you, Chair. It’s dangerous.
JUSTICE NGCOBO  I does leave a great deal to be desired.

MS DA COSTA  We will be explaining the detail, thank you, Chair.

So Lesotho is one of the poorest countries in Southern Africa and I think what is most noteworthy is the significant burden of disease that it has, not too dissimilar to what we experience in South Africa. As you can see, very low life expectancy, you can see the TB and HIV prevalence and the maternal mortality rates, some of the highest in the world.

The government of Lesotho decided to put out to tender a tender that would rebuild and manage its ailing healthcare infrastructure and this would be specifically around the Maseru area. It would be a good component of their health budget and the intention would be to replace the primary care clinics as well as the tertiary facility.

So a new 425 bed hospital was built that replaced the very dilapidated old hospital that was in place, three primary care clinics and a filter clinic literally at the gate of the primary hospital. I am going to go in to detail on that business model.

The primary care clinics were opened in May 2010. We took the first primary care and maternity patients. The hospital was opened in October 2011 so we have a few years of experience and data at our disposal on those facilities.
Just to give you a sense of the size of this contract. It accounts for about 50% of the hospital admissions in the broader area. With [indistinct 39.03] PPP it takes a lot of political will, it is fraught with difficulty, you always get an independent quality monitor. So an independent monitor was selected in Townsend and Turner, we measure a good 1,000 plus KPIs on a quarterly basis. If you don’t meet, be it the quality KPIs or efficiency KPIs, there is an associated penalty. Obviously there is time for corrective action but then there is a penalty.

After a few years the parties that were involved in the funding, and just for your interest, the type of external parties involved in this project included The Development Bank of South Africa, The International Finance Corporation in the World Bank, The World Bank asked the Boston University to just do a study on the outputs of this project, which we want to share with you, but before we do that I just want to confirm Netcare’s role.

So Netcare is the managing partner in a consortium called Tshepong. We managed the design, the commissioning of the facility. While the facilities were being built we played a very proactive role in the skilling up of nurses and doctors. Just for the record, doctors can be employed in the Lesotho model and there were a lot of foreign doctors, so a lot of foreign doctors attracted to the country. A lot of people are
interested in providing healthcare in Africa.

We also provided the information systems to help with the administration of the facility and we got a contract to manage the facility for 18 years.

**JUSTICE NGCOBO**  Are the doctors employed by the hospital?

**MS DA COSTA**  Yes, Chair.

**JUSTICE NGCOBO**  Yes, okay.

**MS DA COSTA**  So before I just touch on the quality indicators, I just want to highlight that healthcare is free at the point of delivery barring a very small co-payment. There is a R10 co-payment for a tooth extract for example. There is a R50 co-payment for a hospital day. Other than that the cost is borne by the Lesotho government.

So the public health faculty of Boston spent three months assessing the performance of the facility in 2013, and I think it is important to share with you the changes and outcomes in a very short space of time.

So even though we reduced the number of hospital beds by a marginal amount, inpatient admissions increased by 51%. Outpatient visits went through the roof. So for
the first time people had good access, good service, no patient was turned away. Deliveries were up 45% but the single most important thing you can get from this slide is the fact that the death rate fell by 41%, the maternal mortality rate down 13%, all of that by putting in the most basic of initiatives, training up the nurses and just insisting that A is done before B, B is done before C, very basic processes, and holding people accountable.

In terms of the new technologies and services that we introduced through this consortium to the country, things you wouldn’t expect, MRI scanners, the first ICUs, [indistinct 42.24] flow theatres. I won’t go through all of them but it is important to share with you that we reduced the waiting time for elective surgery from six months to six weeks and eradicated the hip and knee replacement waiting lists for the Basotho people and we improved access to dental services.

We have had a lot of interest from all over the world in this project, a lot of international visitors and last year we were visiting the facility with an Indian delegation, and we went to see the dental services and there was a gentleman in the dental chair. He was in his 70’s and the gentleman from the Indian delegation said, how are you enjoying the service? The older gentleman just put his thumbs up and then the Indian gentleman said, how many times have you been to a dentist in your life
and he put his finger up. This was his first engagement with dental services and he was so proud.

So, Chair, to your question as to whether this is about the facility, this is a true reflection of the old facility, this is a true reflection of the new facility, but this is not what it is about, this is what it is about, you giving people access to care in a very efficient manner.

So the question you might ask is how is this possible? It is possible. One, it is an integrated healthcare model. The intention is to keep people healthy and out of the system. If people are unhealthy and need treatment you want to ensure that they access care at the right level. You have got to go to a primary care before you can get through to secondary or tertiary. If you somehow appear at the hospital without your referral letter, you literally go through a little gateway, it is called the filter clinic, you have got to show your referral, if you don’t have a referral we have a little clinic on site and we can see you, but you don’t just start queuing at the hospital. So in doing that you alleviate the pressure from the primary facility.

So one, integrated model, two, you employ the doctors, and that has some benefits in and of themselves. There are clinical score cards, they are held accountable for surgical site infections, for readmission rates and the likes, every department would
have a slightly different clinical score card to that effect. We have medical records
there. It is called a [bukana], a little book that the Basotho people carry with them,
they bring their [bukana] through to the hospital and we have at least a record of their
history, and we are able to procure doctor, drugs and surgical’s at government tender
prices, significantly different prices to what we procure at in South Africa.

At a per patient level, you will be surprised to know that the drugs and surgical’s, let’s
call that the consumables, are a crazy 14 times lower than what we charge in South
Africa. I have just got to contextualise that. The acuity is different, people are not
going high in prosthetics, there is a lot of medical cases perhaps, but it is structurally
different to the costs that we are experiencing in South Africa, but it is possible because
one private is engaged in clinical services, you can employ primary healthcare and you
can also participate in the different segments of the healthcare value chain, from
primary care through to pathology and radiology, through to secondary services and
tertiary services.

If I can move on then to the United Kingdom. Netcare has been operating in the
United Kingdom, and I apologise for the typo there, since 2001. So you will recall
under Tony Blair there was some contracts put out for the private sector and I have got
to be honest with you, at the time the local incumbents weren’t terribly interested in
participating, so you had the South Africans and the Australians flying and saying, we
would be willing to look at these contracts.

So initially these contracts were all about waiting lists, how to reduce waiting lists
within the NHS system. So we, as a Netcare, Netcare UK did some large scale
orthopaedic, ENT and general surgery contracts, but what I want to share with you
quite specifically is a pathfinder project around cataract surgery. So the government
wanted to put out a waiting list initiative around cataracts. Its exemplar hospital within
NHS was the Moorfield Eye Hospital. The Moorfield Eye Hospital had a particular
tariff at which it offered its cataract surgery and it was able to do 10 to 12 surgeries per
day. So the contract was benchmarked to Moorfield. Perhaps it is a little bit simplistic
but I think sufficient for the purposes of this discussion.

Notwithstanding, Netcare scratched its head. How do we do this without bricks and
mortar, how do we compete with Moorfield Hospital and a decision was taken that let’s
just think about this rationally. You have got a volume contract over five years. You
have the flexibility and the regulation to go out and negotiate with drugs and surgical
suppliers and get prices below the NHS on that commitment of that contract. You can
employ doctors. You can set up the clinical pathway. You can hold them accountable
in terms of the theatre slates, etc. etc. So on that basis we went ahead and we tendered
and we were able to get that contract and we put that programme in to play through mobile units, and we are going to show you a short video of that, in fact I am actually comfortable if you role the video now. So what you see in front of you looks like, I guess, a container type hospital on an NHS site. What you will soon realise is that this is going to be put on top of a trailer and driven around the country from site to site. So we had six of these types of theatres, six of these types of mobile cataract units. From the inside you wouldn’t know that you were in a trailer but it is effectively a trailer. You can see the waiting rooms, we are going to show you a picture of the theatres. We operated these six days a week 50 weeks of the year. There was regulation on the road that required a certain size trailer so these trailers had to contract and they had to expand on site and you literally went from one NHS site to the next. Patients were informed the day before, Ms Da Costa we don’t want you to queue from five in the morning, we want you to come in at precisely quarter past eleven and we will see you. Very efficient system.

We saw 45 outpatient pre-operative assessments per day, 60 follow up cases. What is critical here is that the more surgeries a doctor does the better he becomes at it. Eventually the doctors were doing 20 to 24 surgeries per day in these theatres and they were finishing at lunchtime and going home. That is the efficiency you are able to
extract if you have got the flexibility in the regulatory environment and the will by all players.

So what you see there is just a connection to three phase electricity at the NHS. It is literally all you need. You can just see the hydraulic jacks and just how simple it was to take it across town.

So hopefully that gives you a sense of the art of the possible when it comes to engagement on how it is that you can either reduce cost or increase access.

So in somewhere in the United Kingdom we demonstrated our ability to deliver high volume surgery and this had two benefits. By the NHS contracting the private sector to deliver clinical services, it had two positive outcomes. The first is that the waiting lists were reduced but a very interesting external positive factor arose and that was the fact that the NHS hospital managers weren’t too happy with this because all of a sudden they have got competition. So what you find is that the productivity of the local NHS trusts started to increase and those waiting lists started to diminish in other areas too.

So it plays a very important role within the public environment. It increases competition from the public sector.

So we introduced more operating and clinical pathways. These outcomes were
published, very closely monitored, so we had good outcome measures and we had very high patient satisfaction levels, and these projects can be implemented in other parts of the world very easily, inclusive of South Africa.

So let’s just talk to some of the collaboration within the South African market. Netcare participates in four private, public partnerships in South Africa. These do not touch on clinical services. These are in effect collocation private facilities if you invest in the public facility.

So we also have some, I guess, secondary or ancillary services, be they the laundry, catering etc. but not clinical services. We have tabled multiple elective surgeries to the various provinces over time. We took the time even through the Hospital Association 2008 to go and present to the Health Portfolio Committee to share the art of the possible. We have gone so far as having the treasury assist unit coming to Netcare and basically benchmark all of our processes and procedures. How do we approach HR, how do we approach stock, how do we replace, I mean how do we approach replacement cycles for Capex, we have handed all of that content over. So a great willingness to engage with the public sector.

I am not going to touch on the other issues because I think we did just a short while ago, Chair, with your question, but I guess what we wanted to share with you is that it
is within our desire to participate in increasing access to healthcare in South Africa, and we think that there are many ways in which this is possible.

I just want to share with you some of the consequences of an inflexible regulatory regime in South Africa. So what you have here on the one side is the NHS reality that I just shared with you and on the other side we have an opportunity that we have tried to launch in South Africa, together with Siemens and CANSA, it’s called. Basically it is a breast screening project. It was intended to serve six underserved communities in the Freestate. It is a mobile mammography unit. It just required that Netcare employ a mammographer. Needless to say we started this process in 2012, it is now 2016, not one patient has been screened. We had at least eight letters to the Health Profession Council before we got a response and we have just had multiple, multiple requests for data, presentations, etc. etc. To cut a long story short we have now donated this trailer to the Provincial Department of Health, and those are some of the sad realities.

I take this opportunity to hand over to Dr Dena Van den Bergh to specifically speak to quality. Thank you, Chair.

**MS VAN DER BERGH** Thank you, Melanie. So I am going to start [indistinct 54.18] which is the concept of the triple aim. [indistinct 54.24] that doesn’t understand that this concept of [indistinct 54.31] the best outcome in the most cost effective ways
essential to any health system. [indistinct 54.39] I also don’t think that there is any health system in the world that isn’t it being challenged to do that better and better, and South Africa and Netcare are [indistinct 54.43] outside of that.

[indistinct 54.52] on the right hand side of the slide I have talked about having a sales based approach to this whole process and we have worked very hard to bring evidence and data to those very broad concepts so it easy to talk about best outcomes and it is easy to talk about best patient experience. In order to evaluate that effectively you really do need to have the correct data, good [indistinct 55.19], good evidence and then to be able to use that data effectively to improve care and to deliver better and better outcomes.

[indistinct 55.30] our technology and ability to collect and collate data at the frontline of care and to bring all of that data into a [indistinct 55.40] that will enable the collection of data and then get that back to the frontline so that they know how they are performing and they can improve.

That has been [indistinct 55.53] the foundation of how we have operated and what we have been working on in our journey with regard to quality of care in Netcare and South Africa.
Now I sit here as an [indistinct 56.06] Netcare executive. I have also been a founder of an organisation called Best Care Always which operates at the public and private sector level to really bring this element of how do we measure improvement and how do we execute change to provide better and better care and we have done several projects within that organisation to bring the [indistinct 56.35] measurement and the ability to change and improve healthcare and I will show you an example later.

So [indistinct 56.43] for quality as we recognise we operate across multiple facilities it was important for us in Netcare to build a robust system covering several aspects of quality in our health system.

So the first one is really talking to quality assurance. This is a well established system in the world. It talks to how we measure and audit quality standards in our system. Netcare has worked with the Department of Health on the national core standards and I personally sat on the task teams together with several other professionals, and we have developed the [indistinct 57.27], and in addition to that, in 2011 we undertook to test the national core standards in the private sector and we trained auditors and ran the existing core standards through every Netcare hospital and we then provided feedback to the Department of Health at the time on what our questions were, what we had difficulty on understanding, where we had gaps and what we believed should be done.
to improve those standards. Those were incorporated and then in more recent versions of the national core standards we have seen some of those elements included.

In addition to that [indistinct 58.15] we didn’t just do it as a test. We made a decision that we would want to measure ourselves against the national core standards, and so we have got data for every hospital in Netcare on our adherence to the national core standards, and we have had programmes to both recognise excellence as well as close the gaps.

[indistinct 58.42] I will show you some of that data. We have shown a substantive improvement across hospitals and we have also made sure that that is true of small, large and medium size hospitals. [indistinct 59.00] and certification to support that. That is happening.

[indistinct 59.12] quality assurance or operational excellence which is innovation and [indistinct 59.16] relates to this concept of technology. However we use technology to leverage the [indistinct 59.25] several new systems. So Mark mentioned the patient feedback system using the iPad technology, using web based surveys from patients, and the [indistinct 59.39] that has been to be able to bring in the information fairly quickly back to the hospital. So in our patient feedback data, every day a manager can see what patients have said about them the previous day. We have exception reports so
we can push by SMS to the hospital management team any information about somebody who may need their attention and their care, and in addition to that they can also get information about where we have provided good care and really support their staff and thank their staff for the kind of support they have given.

We have also put some clinical systems into place, so it is not only about patient experience, because we are aware that the real measure of quality is not just patient perceptions but also how the care is actually delivered and what the outcomes are. So one of our major projects over the last two years has been introducing an antibiotic stewardship programme and an infection prevention and control programme that both the [indistinct 1.49] data and patient data together and helps us identify risks and target our surveillance and our interventions, our isolation and any special care that is required for those patients.

So that [indistinct 1.01] innovation is [indistinct 1.01] and it is intended again to bring the highest value concepts to the frontline so that they unit manager who manages a single ward has the information for her to be able to go and deliver high quality care.

At the second pillar of our framework [indistinct 1.01] product we have three categories of measurement and programmes that we have in place. So I have spoken a
little bit about our patient feedback, I will show you some of the data in a moment. So there is a whole lot of work around patient experience and patient feedback.

The second category of data really talks to outcomes. In the field of outcomes we cover infections, we cover mortality, we cover readmissions, we cover elements of specific lines of care. We really follow a lot of the international focus areas, acute myocardial infarctions, we use the [indistinct 1.02] of care and we track the [indistinct 1.02] data for neonates and we have track all of that measurement under this concept called patient outcomes.

The third level of data that we collect is what we call patient health and safety. So this is measurements of adverse [indistinct 1.02] and any [indistinct 1.02] that may have happened in our structure, so that we can track [indistinct 1.02] around that and implement specific areas of risk management around those.

I meet every month with a group of professionals within Netcare and we review all of that data from the patient feedback to the outcomes, as well as any incidents of harm or [indistinct 1.03] that have happened. We have a system within Netcare of issuing what we call both a [indistinct 1.03] to all of our hospitals, so if something happens in one hospital, we not only do a root cause analysis of that particular incident, but we also do what we call a risk reviewing across that hospital and across the whole of Netcare so
that that information can be disseminated quickly across the organisation, and where that is critical we issue what we call a directive. So, for example, when the Ebola risk was prevalent we issued very specific instructions under a directive to all Netcare hospitals about what to do in the emergency care units and we tracked those using various technology, and every hospital manager, nurse manager, emergency service was required to assure us of those systems being in place.

We also audit any directive based on a certain time frame to make sure that that’s in place. Those are, we do that work both on a daily basis [from the data through specific 1.04] so we are not looking at everything every day, we only being flagged for specific issues. Then on a monthly basis myself and our committee review all of that data.

We also have a board within Netcare that reviews, so we meet twice a year. The board is accountable to the Netcare board, it is a quality board, it has independent board members on it. They review that data twice a year and they give us feedback on any priorities and any areas of risk that they feel should be dealt with and we also report back to them on how we have progressed based on the commitments we have made.

We have strict targets and targets for all of these measures. Our managers are measured on those measures in their performance reviews so we have a balanced score card. Last year in our executive all of our members of our executive had 35% of their
personal [indistinct 1.05] score cards, the quality metrics within Netcare.

It has been a five year journey to identify those measures, to build the capability to actually be able to measure them reliably across every single unit. We have standardised all of our measures for every hospital across Netcare and despite the fact that they don’t necessarily correlate with other health systems in South Africa, we feel confident that our measures are as far as possible aligned to international benchmarks.

We have really had to use CDC definitions, we have used the US and the UK measures as far as we possibly can, to indicate to us what other health systems have done to [indistinct 1.06] measurement system and [indistinct 1.06] we have had to do the whole [indistinct 1.06] down on the ground to be able to collect those measures properly and ensure that we providing our health professionals as well as our leaders the information they need and, I will talk about how we disseminate that data and what we do, and I know you want to know about [indistinct 1.06] with the public and I will touch on that as well, as we go forward.

The third area [indistinct 1.06] is what we call building quality improvement capability, and it is the question of having lots of data but do we know what to do with that data, do our staff understand how to make changes in a [frontline 1.07] of care so that we continuously improve our data. We have extensive programmes. We have partnered
with many quality improvement organisations, both nationally and internationally to learn what it means to create improvement, and really both within Netcare as well as contributing through the Best Care Always programme, we have built significant knowledge in South Africa around quality improvement and the methodology of the science of improvement using your data to really create the impact that we would like to create for South Africans.

So we have programmes in our quality improvement capability. It talks to [majors 1.07] and leaders, so the work we have done to ensure that as a hospital CEO, as a hospital manager you understand the quality metrics, you know what your data is, you are able to talk about that, you can engage with it. So we have a specific stream of work that is aimed at the quality leaders within the organisation and we require that from the hospital manager all the way to the frontline ward nurse leader that she has an understanding of the quality and is capable of actually interpreting and putting in changes for continuous improvement.

We also do a lot of work on the frontline because at the end of the day the work of healthcare happens at the bedside, and so our second stream of work on growing with passionate people is harnessing the talent and commitment of health professionals, and inviting them in to our programmes to build and improve healthcare too, and we are
using an engaged model for building from the bottom up a capability in addition to the leadership that is required.

We have been running a specific programme called the Netcare Way. It talks to behaviours. Those behaviours are all about how we engage with patients, they are all about communication, they are all about respect and I would say that they are about connecting us to the core of why we practice healthcare, the core of what attracted us to be health professionals in the first place, and bringing that care and compassion in to our work, and then we couple the Netcare Way behaviours with the science and the data and the detailed information about what is actually happening in terms of the outcomes within our group. We are very passionate about that, and with around 20,000 employees we have to find ways to efficiently and effectively take that message all the way down to every single person who engages with the patient.

The first [indistinct 1.10] within the quality portfolio. I have [indistinct 1.10] in to what I call clinician leadership. I think traditionally in South Africa, as managers of health systems we had always kind of had our own ideas about what the answers should be and so we would always use this word called buy in. We want our doctors to buy in to our ideas. What we have done is we have been switching that round and asking our doctors to help us design the change, to help us lead the change and to
become part of our system.

So our clinician leadership work has two streams. The one is a very strong stream of clinical governance. It is also [indistinct 1.10] in the world those structures are important, I will tell you a bit more about them. The second stream is feeding the data we have been collecting back to our doctors and showing them how this unit performs, the individual hospital performs and because we have really enhanced our technology, we more and more have data about how they individually perform through the system.

There is still a lot of work to do around the nuances and the science of that but we think we are well on track to be able to do that going into the future and very much support the work that is being talked about here, about us needing to bring that into the public view as we go through.

So our focus has been firstly to collect our own data, to bring it in to something that is reliable, to make sure that the data we [indistinct 1.11] to make visible and to make more transparent is good data and is reliable. We have also taken that through our clinician partners so that they understand what we’re doing so that they have seen the data, they have been engaging with us on that process and I think our third step now we are ready to take the next step which is to engage with the rest of the industry as well as
to share this information more transparently with the public.

**JUSTICE NGCOBO** This process which you are describing, which appears to be quite an involved process, how long did it take? Over how long a period have you been doing this?

5 **MS VAN DER BERGH** I would say that we in the Netcare this [indistinct 1.12] had started many years ago and [indistinct 1.12] together has been five years.

10 **JUSTICE NGCOBO** Yes, okay, but what you are telling us is that it is only five years later that you now going to be able to share this with the public.

**MS VAN DER BERGH** Yes, I feel that has very much been part of this process and I think we have to be responsible about how we can share that with the public. It is not that we haven’t shared anything, I will come back to that if you like.

**JUSTICE NGCOBO** Yes, I understand.

20 **MS VAN DER BERGH** So the second part of our clinician [indistinct 1.13] work is what I call clinical governance and I thought I would [indistinct 1.13], and I know there have been some questions around this to talk about the structures that we have in place for that.
So every hospital within Netcare has a physician advisory board. It is composed of physician representatives, clinicians, surgeons, anaesthetists and management. Together they sit, we require all our hospitals to meet on a regular basis. In our larger hospitals it is up to 10 times a year. In our smaller units it is quarterly, so if it is a 50 bed unit those hospitals would meet four times a year.

At those meetings the data we have been collecting has been presented to doctors so we will do those in smaller pieces so we will sometimes present the patient feedback data, sometimes we will focus on the healthcare associated infections and we will review that with those clinicians in our physician advisory boards.

In addition, any matters of quality that are brought forward through our complaint management programme can also be brought to the physician advisory board, and if there is a particular doctor who requires intervention in terms of quality, the first level of consideration is with the physician advisory board.

We also have as part of that work mortality and morbidity meetings. Those are the normal clinical governance programmes in which cases are discussed amongst peers and in those meetings [indistinct 1.15] health professionals participate in that and they do normal [indistinct 1.15] across the wards and learn from their cases and evaluate what the care could be going forward for other patients.
If the hospital is unable to resolve a matter within their own physician advisory board, the matter can be referred to Netcare’s clinical practice committee. That committee, so there is an escalation of a matter, so, for example, the doctors, a particular doctor may, the [indistinct 1.15] is not wanting to resolve that matter were not able to do that, in the Netcare clinical practice committee we would come back to being able to bring an expert, we have done that on several occasions when we have required specialist expertise to evaluate a particular matter, and that then is decided on using an independent panel going forward as we work through that process.

In the field Netcare [indistinct 1.16] transformation, our [indistinct 1.16] in quality talks to the concept of healthcare in South African and it talks to two things, one, how do we engage with our stakeholders and how do we contribute to improving healthcare in South Africa, not only in Netcare.

When it comes to stakeholders we include Department of Health, we include the provincial departments, it includes the work we do with [indistinct 1.16] always to drive improvement capability and it includes our [indistinct 1.16].

In addition to sharing information with our management and our doctors we also, I personally at the end of last year did 11 presentations to medical schemes. For each of those schemes I talk to the Netcare general system and then for some of the data we
have been able to extract specific data for Medscheme for any of the individual schemes that are maybe visiting that day and, I will present them some of the data on how their [indistinct 1.17] and outcomes perceptions, patient perceptions are performing.

We have been very engaged in [indistinct 1.17.00] to South African professional conferences. So Netcare is actively taking a [indistinct 1.17.00] in a scientific format so that other health professionals can learn. We had 35 scientific abstracts at the most recent quality summit. We have had, last year we had 18 international publications of quality work done and presented at international conferences and we have been, we have got three [indistinct 1.18.00] publications in progress at the moment to do with the infection prevention and the antibiotic stewardship.

So we have really made the commitment to take all of that data and contribute to the body of [indistinct 1.18] both in South African and in the rest of the world. That really talks to the framework that we operate in. [indistinct 1.18.45] which we presented.

So we put together every year an integrated quality report. That goes onto our website and it has different types of data included in that. So if you go onto the Netcare website and you access our quality [indistinct 1.19] report, this is some of the stuff that appeared last year, you will see that [indistinct 1.19] data, we have covered the patient
experience. So last year [indistinct 1.19] thousand patients that came in to our hospitals provided feedback on our patient experience and 78% of them said they would definitely recommend this facility to friends and family, but they also said [indistinct 1.19] quality assurance and audits and [indistinct 1.19] performed against the core standards. The overall rate for Netcare went from 86% in 2014 to 88% in 2015, and you can see the percentage of hospitals that we [indistinct 1.20] measure that we want to make sure that when you see the Netcare badge you are not going to encounter a hospital that is performing at [indistinct 1.20] but that we have shifted all our hospitals to the standard we expect, and we saw that over 90% of our hospitals are above 80% on the national core standards. [indistinct 1.20] over the four years since we started doing that.

[indistinct 1.20] clinical measures now in terms of our [indistinct 1.20] and in terms of both process measures as well as outcome measures as we go through that.

The health and [indistinct 1.20] areas of our measurement have been critical for us and as I said to one of them [indistinct 1.21] commitment to [indistinct] one [indistinct] to act. That [indistinct] is that for any event that happens at our hospital we will make sure that we will learn from every event and act on that not only in the individual hospital but across the whole system and it [indistinct 1.21] in South Africa to make
sure we do that across the whole country and not just limited to our individual groups we go through. [indistinct 1.21] it certainly [indistinct] we do that, at our quality summits we share our learnings across the industry but I think we can do more, and we can do more to do that more quickly and more efficiently as we go through that process.

I think I have covered all of the other elements in the discussion of [indistinct 1.22] but if you would like to ask me any questions on those you are welcome to.

I have talked to the quality assurance process. You will see that I have put one of our graphs. We have obviously the public are very concerned about the issue of healthcare associated infection. It is true that around the world that is one of the high risk areas for healthcare and we have spent an enormous amount of time driving risk management strategies around infection. That particular example is central line infections. It is a measure that many, many countries in the world are driving. There is a specific [indistinct 1.22] of care that is internationally recognised to prevent those infections. We are tracking the compliance to those [indistinct] of care so we have got measures within our wards where we measure central line [indistinct 1.22]. That took us about five years to put that in reliably and to ensure that we actually adhere to that using checklists and this last year also put that in to our electronic platform so that the
central line [indistinct 1.23] are captured every day and we can then measure that reliably. You have seen what happens in terms of that number and with central line infections.

I can honestly say that in the [indistinct 1.23] this is one of the projects that we did collaborate in across both public and private sector and last year and the year before we collated data. All of these four bundles are specifically on central line infections and we had an independent person from [indistinct 1.23] healthcare improvement help us bring that all together. So we all sent her some of our data for a period of time and we presented the improvement across the whole of South Africa, and I think that was a milestone for us to see what the possibilities were just taking one area that we all had worked on and since this was started in 2009 and we were able to bring the capability, both to some provincial hospitals who participated, as well as with [indistinct 1.24] selection and then many of the private providers collaborated with us, and we brought that data to the forum just demonstrating the possibility of that as we go through that.

This is some of our patient experience data. You can see we started measuring them using the hospital consumer assessment method and the HCAHPS method it has become. The one thing about that measurement, the way you look at it there is always a question of why use a US benchmark? The fact is it was one of the few available in
the world that was standardised, and so they made the decision to do that so that, one, we would have a standard measure, [indistinct 1.25] there is a measure something called patient satisfaction so their measure of patient satisfaction and our measure of patient satisfaction had no relationship and so we recognise that that wasn’t specific enough. So we introduced these measures within 2012 and we have measured those across the whole of the Netcare system and then we were also able to look at why do the USA HCAHPS hospital, I would say it is about 3,600 hospitals that are required to use this particular measure and report on it, and we were able to show when we first started that many of our measures, you know we [were 1.26] meeting all of the requirements and we still have a way to go in terms of where the US may be in those areas, but they have also shown some substantive improvement. [indistinct 1.26] is not only by having lots of measurement but by also bringing, engaging the staff on how we could to that better and better. We have had programmes around that, we have had [wards 1.26] to support staff so we are wanting them to be recognised for their work and effort in this work and we have also done a lot of clinical work around it so [indistinct 1.26] needs a review of the pain regime, so in that we can engage with our anaesthetists, we have to engage with our doctors about what they prescribe and how frequently it is being prescribed, what the latest thinking is about pain management,
and then how the nurse administers the medication, how she explains it to you, and what systems we have in place is a second part of that.

So this work although it seems like it’s only patient experience, it actually has to be integrated with your care plan as well as how people are feeling about it. The questions are very specific, they are frequency questions. So they ask you, how often did the nurse treat you with care and dignity, how often did your health provider provide you with information about your medication? So they're really asking the public how they reliable programmes are, not only, you know we have a few brochures on our website. It is actually asking how often we actually did the standard that was required in the process.

So that is [indistinct 1.27] and if there is anything later on I am sure I will be happy to answer. Thank you everybody.

JUSTICE NGCOBO  Yes, thank you.

MS DA COSTA  Thanks Dena. Thank you, Chair. The next section we are just going to have a change of topic. An apology is that there is an error on the slide. This is global benchmarking and cost comparisons.
So the first thing I want to share with you is just the breakdown of the total cost of running Netcare Hospitals. and Professor Fonn, you have in particular been asking the question around the economies of scale and this goes to what level of fixed cost is in a business versus the variable cost that is in a business. Generally across all hospitals in the world you find that the mainstay cost of a hospital is the origin of the facility and then in terms of the operation of it, it is the cost of the healthcare professionals, many places do employ doctors so that would be a doctor, that would be the nurses, and then it would be the consumable items.

In South African within the Netcare portfolio, because we don’t employ the doctor, the drugs and payroll and consumable items is effectively 80% of the total cost of service. So that is the cost of sales plus the operating costs. So I am guessing that that is significantly more than you could have imagined and as a function of this, the economies of scale are perhaps not what as what is expected out there because if you are running an efficient business at a certain level of occupancy, you want to be able to scale up and scale down, based on patients coming in, so hence we keep anywhere between a 15 to 20% slack in nursing, and what that means is we use agency staff to top up so that we can be a little bit more flexible in the efficiencies in our business. So the variable component of cost in the business is significant.
With respect to payroll, Professor Fonn, you have also mentioned questions about what has happened to the standard of nursing, numbers of nursing in the country. I just want to share with you that at Netcare over many years we have had iterative improvements in the way that we manage nursing. We have a clinical nursing tool that we believe is quite unique, uniquely so that the NHS is piloting it themselves. What this tool does is it matches the nursing requirement to the patient, based on clinical assessments twice a day.

So in terms of the question as to whether the number of acuity or the number of nursing hours has dropped for nurses, first I want to explain what acuity is. So acuity refers to the number of nurses or the qualification of a nurse. So dependent on the ward you have a certain number of hours that the nurse would spend with the patient. So, for example, I am going to give you the trend of nursing acuities from 2006 to current, 2015. For a general ward, for example, in 2006 the nursing acuity was 5.7. Basically that means that the nurse would spend 5.7 hours with every patient in that ward every day. Last year it had gone from 5.7 to 7.1. If we look at the general surgical ward it was 5.4 and it is now 6.5., so it has increased. In high care it has gone from 14.9 to 16.1 and at an ICU level it has gone from 16.6 to 18.4. So that means a patient that is sitting in ICU, critical state, you have got nursing care pretty much the whole day.
So hopefully that evidence and that data lays to rest any questions with respect to nursing, certainly within the Netcare portfolio.

Another question that was asked is whether there were unusual admissions into ICU and high care versus general ward due to some anecdotes around the quality of nursing.

Just quickly looking at the growth in volume, over the last three years in ICU, high care and general ward, I can say that the evidence also doesn’t bear that out. We have had a slightly higher growth rate in ICU and high care but no more than 0.3% over that three year period, so the differential isn’t that big.

So just moving on to global benchmarking, this is always fraught with complexity, and you are always going to have players on one side of the table or the other side of the table that is not happy with the content, so you have got to apply your own mind. I am also fiercely independent that way so I am going to share with you just how I apply my mind when I look at these things.

So firstly we know that we had an affordability study or a benchmarking study published by the OECD. Chair, we would have loved to have given you a response on that today. We do have our economics team looking at it. We did put a formal request through to the OECD for access to that data. They have now formally come back to us
and denied us access to that data. So we weren’t engaged before the report was published and we are still to be engaged and we still haven’t had access to that data.

Notwithstanding, in terms of the methodology, we feel that we can still engage you and just put our thoughts to you, but it is important to stress that the report, certainly in my opinion was an affordability study and affordability studies are so complex in a country with such significant Gini coefficients. The sad reality in South Africa is we have 70% of our population that live in households that earn less than R10,000 a month. Affordability is a grave problem in this country and we accept that.

With respect to a global comparisons in general, I have just shared with you the primary cost drivers to the exclusion of doctors, but the primary cost drivers in running hospitals, nursing, consumables, the cost of building a facility. If you want to compare Netcare South Africa to Netcare UK, for example, it is unfair to go to the UK and say, UK you are inefficient because you are so much more expensive in the delivery of a procedure than your Netcare hospitals in South Africa, because the cost of nursing in the UK is double the cost of nursing in South Africa. The cost of building a hospital in the UK, the last time I saw, is probably a little bit outdated now but it was a £1 million, that is R20 million. So you can’t compare costs that easily, you have got to look at the
local realities of what informs costs.

Similarly, I shared with you an example in Lesotho. Lesotho is much cheaper than South Africa. India is much cheaper than South Africa. The reason for that is you have got nursing salaries that are even regulated at a minimum wage in certain provinces such as [indistinct 1.35.02] where you have got nursing wages that are let’s call it half of what you find in South Africa. India has also got much cheaper building costs. In truth I think that the regulation is not as strong as it is in South Africa so the quality of build is not what you would expect to find in South Africa so I don’t know if that is a positive thing, in truth.

The other thing that I want to highlight to you is consumables. Your drugs and surgicals. So you had two presentations yesterday that benchmarked the cost of drugs and surgical’s to India and to Switzerland. You would also find in the submissions that Netcare has made, we have shared with you our cost benchmarking to the United Kingdom, and we found similar discrepancies, and Anthony is going to be touching on that a little bit later. So the cost of consumables and surgical’s in South Africa relative to our own business in the UK is significantly higher, notwithstanding the fact that we have 10,000 beds in South Africa versus just short of 3,000 in the United Kingdom, and our occupancies in South Africa are also much higher than they are in the United
Kingdom. So it is not that simple to compare hospital prices across borders.

The other thing I want to highlight to you, which is something that I have personally only come to learn over the last two years is that certain countries in terms of consumables are thoroughly affordable because they are a little bit more relaxed with what is termed reusable’s. So you have got surgical items that are marked by the supplier as single use and in countries such as India you will have multiple use of such items. We are talking guide wires for stents, you talking catheters etc. etc. and I put a reference in the slides for you. The reuse of some of these items can be as high as 50 to 80. The quality outcomes is something that you have to measure at the same time as you are measuring costs.

There has also been some cost benchmarking done in South Africa. It is not a perfect science, we have very little access to public sector data, but a few years back we asked the head of the Actuarial Health Department in Cape Town University at the time to look at the cost of delivering services in the private sector versus public, fraught with difficulty as you can imagine. As a starting point you are going to find private is much higher than public. Then you start adjusting for some of the differences if you want to do a benchmarking. One is charged VAT, the other is not charged VAT. One is charge corporate tax, the other one employs doctors, so you’ve got to make that
adjustment. The one subsidises the other in terms of drugs and surgical’s. So it is a comprehensive report that was put to the panel and to the inquiry. It is worth the read. What it does say is that once you have adjusted for vacancy rates and for all of these other items, the cost of delivering the service is pretty equivalent at an admission rate.

I just want to tell you that at a patient day rate it isn’t. It turns out the length of stay in the public sector is significantly higher. That could do with the acuity of patients, it could do with the fact that people haven’t got a place to go afterwards and they might stay in hospital for a little bit longer. It is complex. The moral to the story is if you want to compare as close as we have been able to come today on a like for like basis in South Africa, that is the differential. If you are not happy with this approach, because there is just way too many things being adjusted for, what we can share with you is that the Department of Health also runs some private wards. They are called the Folateng wards, and they use tariffs that are not too dissimilar to private tariffs with medical schemes, something if you wish, you could engage the medical schemes on and the Folateng private wards in four Gauteng public hospitals ran a loss in the 2014 period. So that gives you an indication of the reality of the costs of delivery.

Just going back one slide …

JUSTICE NGCOBO Given all these qualifications, what is the value of this?
MS DA COSTA  When we do cost benchmarking, Chair, it is just critical just to take all of the various factors into account. I think that is all it states. There’s nothing fundamentally turns on it but if you do want to throw stones in terms of one being efficient or inefficient, as comprehensive and as robust an engagement around it as possible is appropriate and necessary.

So if we look at the development cost of hospitals, and that is the cost of building a hospital between the private and public sector, there is a current collaboration and engagement going on between the CSIR, The National Department of Health, and the Southern Bank of Africa and they have tabled a basic hospital model, and just comparing the costs of build between the private and public sector we can also say that we benchmark pretty similarly. We were upset about that, we thought we would be more efficient but notwithstanding.

So, Chair, just in summary on that the purpose is not one is better than the other or vice versa, it is to highlight the complexity of cost benchmarking and the need for all parties to be engaged from the outset in these engagements, in these discussions.

So, Chair, just moving on to the regulatory regime. The first thing that we as Netcare want to state is that it is undoubtedly true that for a sector as important as healthcare, some level of regulation is appropriate. It is also correct that the nature and the
requirements of these regulations, as well as the manner in which they are administered can become burdensome and it can at times result to costs that are not as effective as one might desire.

So when you consider the regulatory environment in South Africa, you obviously have to consider the challenges faced, not just by private sector but certainly by public sector, too. They don’t need repetition but it is the very high burden of disease, significantly higher than other developing markets, too, and we will share with you a comparator on that. It is not only a high burden of disease but a grave shortage of healthcare professionals, and I am going to elaborate on. Together with that there has been a reduction in the number of hospital beds within the public sector. I will also elaborate on that. As a result of this, it is just fair to say that the environment in which we operate can at times be constraining. We cannot be as flexible as we would like to in terms of meeting patient needs, be it scaling up occupancy, taking down occupancy, bringing in new doctors etc. and obviously all of this comes with an associated cost.

In 1976 there were about 120,000 hospital beds in the country. We had a population of 25.3 million people. In 2014, to be precise, I mean there has been a little update on that but the most recent data reflects that we have 122,000 beds. The break up is 37,000 plus/minus in the private sector and about 85,000 in the public sector. So
there has been a significant contraction of capacity within the public sector and that is obviously been compensated for by additional capacity being added in the private sector. So we had 4.6 hospital beds per 100,000 population in the 1970’s, we currently have 2.25 and that is skewed. It is skewed against the public sector where the public sector has significantly less. In terms of international targets on what hospital beds should you have, you could all have I am sure your own opinion on this, my personal sense is that I would probably be more comfortable with a three beds per 100,000 population but your opinion is probably more informed than my own. On that basis we would probably still require a good 40,000 beds. 40,000 beds is pretty much what the public sector has closed over the last decade and a half, if not slightly more in the country, and as a result of that, private sector has become increasingly more important in the delivery of healthcare. You see within the medical scheme population people are free to access public health. Only 0.3% of medical scheme expenditure is spent on public hospitalisation. So that is just a point of context.

In terms of the understanding private healthcare, some of the key features that we need to appreciate and at the same time so complex in and of themselves, the first is affordability. Affordability is of critical issue in South Africa and I am going to elaborate in a little bit more detail, but yes, principal members of medical schemes are closely aligned to that of employment, and if you recall that a lot of families might
have two people that are formally employed but one principal member. What we have found is over a good 10 year analysis, you tend to find a relationship of a good 40% of that formally employed are principal members of medical schemes.

So, yes, we have seen a two million growth or just over two million growth in medical scheme beneficiaries since 200/2001. 50% of that has been a function of GEMS and Discovery Keycare Health and the rest has been a function of employment.

The South African private hospital sector, we have seen significant level of investment and you have seen the reverse occurring in the public sector over the last while. Obviously a key feature is that of regulations which you well know.

So what you have over here is a graph that just highlights in the purple the formal employment figures, in the light blue we speaking about medical scheme membership. What you see in the green there is personal tax. The reason why you might ask is this relevant or not, it is just important to understand the extent of the affordability constraint in South Africa. We have 13.7 million people registered as tax payers in this country but only 5.6 million people are liable to pay personal tax. 860,000 South Africans pay 70% of the personal income tax in the country. That is how grave the affordability constraints are. That is the type of pressure that the public sector feels because there is just so many people dependent on the public sector.
If we turn to this next graph it actually reflects this nicely. The long and short of it is 80% of people that live in households that earn R20,000 per month have medical cover. The bulk of our population, 70% of our population are sitting in this quadrant, and apologies to the panel that you can’t see that, but that is under the R120,000 band per annum and that is per household. Hence the importance of having a collective discussion around private and public at the same time as we discuss how it is that we can increase access, because we are not operating in isolation of each other.

If we go down to province level, this is Council for Medical Schemes data as well as Labour Force survey data, it looks at the employment in the various regions and the medical scheme membership. So the medical scheme coverage is in the bars and the percentage of the population formally employed is on the line graph. So you can see Gauteng, where you have just short of 50% of the population formerly employed, and this is in the age brackets 15 to 64, you can see that you have and over 25% medical scheme coverage, once again, that one in two relationship. In a place like Limpopo where your formal employment is so low, you will find an equivalent level of low coverage of medical schemes.

So, Chair, the next topic and the next five slides talk to the topic of expenditure in private healthcare, and beyond general price inflation what has been the contribution of
volume/utilisation and real price increase, but, Chair, my sense is that over the last few days this has been expanded on significantly, or the last two weeks, it is not clear to me that I do need to repeat it, save to say that I think all of the role players are on the same side, utilisation has played a significant role here. We would be very happy to take questions when the question time comes, if that suits you and we can fast track to page 52, if you are in agreement, Chair. Are you happy that I do that, Chair?

JUSTICE NGCOBO  Yes indeed, thank you.

MS DA COSTA  So just back to the impact on the regulatory regime, I just want to close off this discussion, and that is that we have to operate within the legal constraints of our country and, yes, there are certain structural features that are impeding increase to affordable healthcare. In short, if you want to treat a patient you need a doctor, if you want to treat a patient you need a nurse, if you want to treat a patient you need medicine and if you want to treat a patient you need the facility, whether it is a facility, whether it is an ambulance, whether it is a theatre. The question is, how flexible are you? What is the availability of these items, what can we do to make these as effective and as efficient as possible? In an ideal world we would like to employ doctors, in an ideal world we would like to train doctors. In an ideal world we would like to not have restrictions on how many nurses we train. In an ideal world we would like to parallel
import drugs and surgical’s. We know that that might be a pipe dream. The question is, which of those items might have the most impact in shifting the dial on the cost of healthcare in South Africa?

So there are quite a few elements of regulation that one would touch on. I certainly have not listed them here, but for the purposes of the overview …

**JUSTICE NGCOBO** If you were to employ doctors, if you were to employ specialists, would those specialists remain available to other hospitals?

**MS DA COSTA** So, Chairperson, when I ask myself, of all of the items, if you could choose one or two things that would shift the dial in healthcare in South Africa, what might that be? So I have shown you examples where the employment of doctors really does help extract deficiencies. The problem with the employment of doctors, and I just said in an ideal world, the problem is in a minute I am going to show you the availability of doctors in the private and the public sector, and you will appreciate that the risk we run, as much we say yes it will extract efficiencies in the private sector, the risk we run is that there might be doctors that are currently employed in the public sector that might be tempted by those packages because they want to be employed. So question number one, is that realistic?
JUSTICE NGCOBO  I wonder if you could answer the question please?

MS DA COSTA  Question number two then would they be available to other facilities?

We don’t have that type of contractual nexus at the moment in South Africa, so I think that I would be pre-empting any discussion on it. Instinctively the answer would probably be no, because you would be inculcating perhaps your processes, your efficiencies, etc. So I am not informed on that but my instinct would be probably, no.

Does that answer your question, Chair?

JUSTICE NGCOBO  Yes. What I wanted to know is whether or not they will be available but your answer is, no they will not be. Thank you.

MS DA COSTA  Part of the debate could be, and as I say, that is not a discussion we have had internally, is how could we perhaps use those doctor resources within the public system, so maybe there could be some collaborative arrangements between let’s call it Milpark Hospital and …

JUSTICE NGCOBO  Unless, of course, you allow them to do moonlighting, that is work at your facility during the day and allow them to work at other facilities in the evening which may well have an impact on the quality of care.
MS DA COSTA  So, Chair, it is not a discussion we have had, and moonlighting of doctors, it is an interesting concept but I am not informed on that discussion.

So just moving on to the different pieces of regulation, I would like to invite Barry Childs just to share a little bit more on the Medical Schemes Act. Thanks Barry.

PROF FONN  Sorry, before you do that you were going to say which were the interventions that would give you the biggest impact in terms of cost containment.

Which are they?

MS DA COSTA  So as I have been reflecting on this, and I am looking at it at a systemic level rather than a Netcare level, we are going to touch on, after Barry has chatted, we are going to touch on the availability of doctors in the country, and I think it is going to jump out at you at just how big an issue it is. Without more doctors you are not going to have increased affordability and access, and I think if there was one initiative that we would really apply our minds to, is how do we get more investment in to private or in to education in South Africa but how is it that we could double the number of doctors. If you increase the competition in doctors you would increase the competition at a hospital level, GP level, specialist level. I think the big game changer here is the number of doctors in our country.
MR CHILDS  Thanks Mel. Good morning panel members. I am going to take you through some medical scheme legislation issues and the impacts thereof. You will have seen some of these before, and in the interest of time and so as not to bore you, I will skip over some of the unnecessary detail. I would be happy to come back to any of the detail points in questions.

As I said, to cover what you know, we are under the regulatory coverage of the Medical Schemes Act which came in to effect in 2000. This Act, amongst other things, introduced a set of social solidarity principles, including open enrolment, community rating and a set of prescribed minimum benefits, so that anyone can join and for the same benefit package, that everybody has to pay the same irrespective of health status, and it introduced this minimum set of benefits across all medical schemes and options.

Now, these principles amongst, while also providing the social solidarity protection I mentioned, also had the effect of limiting the extent of competition between schemes. In that Medical Schemes Act they also introduced fixed regulatory solvency levels at 25%, which I will touch on.

It was originally intended that these solidarity principles would be counter balanced by
further regulatory reform, things like mandatory membership, which you have also heard some about. Also mechanisms to limit competing on the basis of risk profile.

The intention of these were to, as I said counter balance the expected cost impact of the solidarity pillars by addressing risk of anti-selection. This anti-selection risk manifests in a few different ways, which I will show you some data on in a couple of slides.

Now, the reality is that these counter balancing reforms did not happen for whatever reason. So we are left with half of the set of regulations, the ones that provide social solidarity protection, but not giving the system the regulations that give it the sustainability needed.

**JUSTICE NGCOBO** Is that provided for anywhere in the Act?

**MR CHILDS** No, Chair. As I said, those regulations were intended to be developed and promulgated but they never came in to the Act.

**JUSTICE NGCOBO** Yes, I understand that but is it stated anywhere in the Act that there will be regulations which will deal with mandatory membership, or was it part of it, it was just referred to in the policy documents?

**MR CHILDS** No, it is not in the Act.
JUSTICE NGCOBO  It was just in the policy document, is it?

MR CHILDS  Correct. There were a range of policy documents in the public domain between, I would say, the late 90’s and 2005 to 2007.

JUSTICE NGCOBO  And when the Act emerged it didn’t have those.

MR CHILDS  Yes the Act, the Medical Schemes Act, 131 of 1998 implemented in 2000 didn’t have them in as yet, the discussions were to include those, and when the Medical Schemes Amendment Bill was tabled with some provisions for risk utilisation [funding 1.56.39], that was never finalised.

I am going to touch very briefly on solvency. There are a few slides here, but I am going to gloss over them and you can come back to me on any questions.

The long and the short of the solvency issue is that schemes are required to hold 25% of gross contributions in reserves. It is widely acknowledged that this is an incredibly blunt and immature means of a solvency protection for medical schemes. It doesn’t take in to account any particular risk aspects of the scheme. It doesn’t take in to account size, risk profile, variations in surplus or deficits, it doesn’t take in to account reinsurance. It means that some schemes hold more than they should be holding, from an economic capital point of view, and some schemes are holding less than they should
be, from an economic capital point of view. What it meant, particularly in the first two years of the decade 2000 to 2004 when schemes were required by the Act to build solvency up to 25% was an extra burden on scheme contributions so that they could build up the solvency. If you look at the operating result of medical schemes over that period you can see schemes making much higher surpluses than in the years following.

So [indistinct 1.58.00] we sit with almost R50 billion in accumulated funds of medical schemes with incredibly tight investment regulations, and that money is sitting there essentially in cash for no other reason than to meet the requirements of the Act at the 25%.

One other important aspect of the solvency that I want to touch on is that schemes can only build solvency through operating surpluses., in other words, the difference between the money that they collect through contributions and the outgo that they must pay through expenses and claims. This is unlike, say, an insurance company, a general insurance company or a life insurance company who, to raise solvency capital or operating capital, can go to the market and either raise a loan or raise equity finance, etc. Medical schemes aren’t able to do that, therefore the only way they can build solvency if they are required to do so under the Act is to increase contributions. This obviously penalises growing schemes and counter intuitively gives schemes that are
shrinking, who may be in decline, a higher solvency ratio. So while they may look
good from a solvency perspective, that doesn’t necessarily indicate their financial
health. It also has the effect of being a barrier at entry to new schemes. As I said, you
can’t go to the market and raise capital. You are required by law over a five year
period to get to the 25% and that can only happen through inflated contributions. All
of that said, that gets us to where we are. We recognise Circular 68 of 2015. The
Council has published a discussion document on risk based capital framework.
Unfortunately it comes 16 years into the process of schemes having to get up to the
25%, but we hope that that will have an improvement of the way that schemes are
measured on statutory solvency in the future.

Chair, I think the main focus of ...

**JUSTICE NGCOBO** There are no exceptions to this amount, to this percentage, is it?

There is no exemption, there is no …

**MR CHILDS** No to my knowledge there are no exemptions. There are schemes that
don’t meet the 25% and I think you heard from one or two schemes that presented that
the Council asks for business plans on how they are going to get to the 25%.

**JUSTICE NGCOBO** If you can’t demonstrate that you can’t enter, is it?
MR CHILDS  You can’t enter, is that the question?  Yes, so if you want to bring a new scheme to the market which there haven’t really been any, particularly any open schemes in the last, in recent memory, you would have to bring a business plan that would demonstrate to the Council how you are going to reach the 25% in the prescribed period.

Anti-selection and adverse selection.  This is also something that you would have heard about from a couple of different stakeholders, and I would like very much to present the data and evidence to you on this point.

[indistinct 2.01] rating preclude schemes from turning applicant members away and they also preclude schemes from charging patients different premiums based on their risk profile.  Premiums can only be differentiated, based on the benefits that are offered, so different options have different premiums.  Schemes can offer different premiums for a principal member, an adult dependant and a child dependant and they can offer different premiums for income levels to facilitate income cross subsidy, but no other differentiation is allowed.  This creates an incentive for younger and healthier people to join only when they are older or when they need cover.  For example, in childbirth, that is a typical example, anti-selective behaviour leads to deteriorating risk profiles within medical schemes and for the industry, as a whole.  It leads to higher
costs for beneficiaries of all schemes. This is given the term, the much maligned term, the actuarial debt spiral, which is a little dramatic. What we have seen happening, actually, over the period is what we might rephrase an actuarial death trickle. It is not a cataclysmic effect, it is a small effect every year, but on a cumulative basis over an extended period of time it is extremely significant.

You will have seen a graph similar to this before, but looking at the shape of the South African population versus the age distribution of medical scheme members, the shapes are quite different. There is a big drop off in coverage amongst medical scheme members in early adulthood. This is often when children drop off as child dependants on their parent’s medical scheme and they don’t immediately re-enter the medical scheme market on their own, again, until they perceive the need for cover.

It is useful [indistinct 2.03] to compare to the South African population as a whole, which is quite skewed to the left for other reasons, but also to compare it to the population above the tax threshold. So there is a little bit of a dip there. Again, these are people in households, looking at the income levels at a household, so there is this little bit of a dip into early adulthood which again is as the child leaves the household and starts to earn on his or her own, he is not necessarily at that kind of income level, but it is very clear that between, say, 20 and 35 and 39 there is a significant shortfall in
the medical scheme membership that we would expect, because it is not compulsory, and a significant higher prevalence of medical scheme members in the tail above the age of 40.

What I don’t think you have seen before, Chair and panel, are that this is not a once off effect. So I know Dr von Gent asked this question, if it is a once off effect of anti-selection then why would we argue that it drives inflation? Well, it is not a once off effect. If I show you the graph on the right hand side first, this data is collected from Council for Medical Schemes statutory return data which contains the age distribution of beneficiaries for all schemes by a scheme, it also includes the gender mix, and we have been able to collate this data over the ten year period 2002 to 2012. What you can see, if I built the slide on an incremental basis, you would see that every year the distribution changes little bit by little bit.

The graph on the left that I have shown strips out the interim years and just shows 2002 to 2012 and the kinds of things that you see are a higher proportion of under one’s. I don’t have it in these slides, but if you look at the cost code of the per life [indistinct 2.04] cost by age, under one’s cost medical schemes a lot of money because neonates cost a lot of money, etc. So those patients cost medical schemes a large amount. Then the tail of the distribution again you find that looking at 2012 the tail is heavier, more
all the people in the system than there were in 2002.

So the data suggests, and I would stress the point that this is not anecdotal data, this is systematic data looking at the industry in aggregate, obviously it will be experienced differently by different medical schemes, but looking at the industry in aggregate, there is an incremental effect every year of this aging and anti-selective process.

We can directly then quantify the impact of this change in demographics over the year, overall taking in to account demographics and a burden of disease measure, which I will describe to you in a moment, we calculated that this has the impact of a 2% per annum increase in the cost of medical scheme coverage. The way that we did this was to look at the PMB cost curve which is publically available, by age, so we know that healthcare costs vary by age, we applied those different age profiles to that PMB cost curve every year and we can quantify the effect. The aging effect on its own at an industry level is about 1.3%. On top of that we were able to use a publically available risk equalisation fund data which was unfortunately only published to 2010 in the public domain in the detail that we would need to do the numbers, and what it allows us to do then is quantify the burden of disease impact over and above aging, and that gives us another .6% per annum. It actually gives us a floor estimate of the change in the burden of disease, because we’re, by definition, only measuring the change in
chronic incidents of the CDL conditions and not measuring, we don’t have publicly available data for the industry for the non-CDL conditions. So that gives us a 2% floor estimate of what has been termed the demand side drivers of healthcare cost. So that means everything else equal, if nothing else changed and all we were able to witness is the changing demographics and the changing burden of disease over the period, we would be talking about a 2% impact per annum.

**DR VON GENT** [indistinct 2.07] clarification, it is aging as such or is this aging of the population because, or included in anti-selection?

**MR CHILDS** It is aging of the population as such with anti-selection included in the calculation, yes. So there is natural aging and there is the effect of anti-selection over and above that.

Perhaps before I leave this slide, the point I want to make is that if you look only at the average age of the medical scheme population, it hasn’t changed that much. So this is the green line in the graph and it bumps around a little bit, but if you look over the period, it is a fairly stable number. We argue that you can’t look at the average age only because the cost impact of aging or change in the age distribution depends on just that, the distribution, not the average age. The population could stay 35 years old, but could expand in the under one’s and in the over 65’s and costs would go up
significantly. So you have to look a little bit deeper than just looking at the average age.

So to touch on [indistinct 2.08] in previous discussions in the last couple of weeks, there is a question of causality in correlation. We can see this, but do we have a case study? Can we show, can we construct an environment against which to test this hypothesis that there is anti-selection? As it happens we have as close to a case study as we can derive right in the industry.

If we consider the change in contribution increases for restricted schemes compared to open medical schemes, over a 13 year period we see a stark difference. The graph you have in front of you is indexed, just to remove the differences in absolute levels which are driven by other factors, for instance differences in administration costs, etc. but if you look at the rate of increase of the premiums of restricted medical schemes, they have been going up by 2% per annum less than open medical schemes over the period.

On a cumulative basis over 13 years that amounts to about a 30% difference. If we considered the impact on the industry, as a whole, restricted and open medical schemes that would get us to about a 15% impact, in other words, contributions are 15% higher than they could be under a mandatory environment regime, which gets us to about a R20 billion difference in terms of current contribution levels off the current base.
Thank you, Chair.

JUSTICE NGCOBO  Thank you Mr Childs.

MS DA COSTA  Thank you Barry. So, Chair, we are now just going to move on to a couple of slides just talking to the issue of doctors. So just expanding on the topic of the shortage of doctors, what you see in front of you now is an analysis done by Iconic in 2015 that just looks at the number of practitioners actually operating in South Africa, so not just registered with the Medical Council, but actually to the best of their knowledge from the analysis they did, present in South Africa.

So the 60 in and of itself looks low, that is 60 per 100,000 citizens, but lies a lot of information and if you look at just GPs alone, the public sector has a ratio of 25 GPs per 100,000 population, the private sector has 92. So what we want to stress in that is that even the private sector fares very poorly in terms of the number of doctors versus other comparators, but obviously the situation in the public sector is absolutely dire. This goes to the complete understanding of the impact on competition because it effects competition in healthcare in absolutely every single level. Just to put this in context in terms of doctor numbers, Brazil, for example, which has half of South Africa’s burden of disease has 189 doctors per 100,000 population. Just to add another statistic which I think is important on this, if we look at the Netcare doctors,
the doctors that are operating out of Netcare facilities, the average age is anywhere between 50 and 55, so just bear that in mind too when we consider the number of doctors in our country, is just the aging population of the doctors. If we look at specialists you can see that that situation looks infinitely worse. I would like to just also split out the private versus public sector because that is critical. The number of specialists in the private sector per 100,000 population is 86. So if you run your 86 across you can see exactly how it ranks, it does not rank well internationally, but the situation in the public sector is heartbreaking at 5.6 specialists per 100,000 population.

So I just want to go back quickly. So when you consider the shortage of specialists in the country, there were some questions posed in the last two days about if we had the opportunity of taking one speciality versus another speciality, and giving a particular doctor admitting privileges, which one would you choose? Across our portfolio any one time we have a pretty good sense of the types of specialities that we are short of, where there is a demand either because there isn’t that speciality at a hospital, or because their waiting list for the specialists that already have consulting rooms on site is very high. So we would try and source those doctors that are in short supply. It goes without saying, given the fact that we have such few neurosurgeons in the country, for example, or neurologists, that we would take a neurologist before, for example, a
dermatologist, it also goes to levels of care, appropriateness of care, etc., but I just thought I would expand on that.

Now, this is the burden of disease. We don’t need to expand on it. There is a lot of research on this. South Africa fares badly relative to developed countries and I think that that is perhaps expected. I think what is heartbreaking is when we see how South Africa fares to other emerging markets and specifically the BRIC countries.

So we are all on the same page with respect to the shortage of doctors. The Department of Health has absolutely no difference of opinion. They recognise the many challenges that exist with respect to human resources, not just in doctor training, but across the healthcare spectrum, and they go so far as to say that they too understand that doctors are mobile. So this goes to any regulation that is implemented and any thought process around future regulation. We can ill afford not attracting more doctors, not attracting more youngsters to study medicine in South Africa, or not attracting doctors to our shores from offshore. It is in my opinion that we should be doing everything we can in applying our mind on how it is that we could increase the number of doctors being trained or educated in South Africa.

This takes me to the next topic which is our training capacity. We have a very limited number of medical schools in South Africa. The training capacity has been increased
slightly over the last few years, perhaps another 200 seats or so, but in short I think it is a fair statement that it has been stagnant now for several decades, notwithstanding what has happened to the population. I mean as I mentioned, the population has effectively doubled since the late 1970’s. So even, though, there has been aspiration to increase the number of graduates being educated, it is obviously more complex than that, otherwise we would have already done that. Obviously we have explored other alternatives outside of South Africa, specifically Cuba. That in itself is not a sufficient structural solution.

So as a result of not increasing the ratio of medical schools, the population ratio to medical schools has increased. If you look at this graph, specifically 2013 you can see that South Africa has basically a medical school to every 6.6 million population and how that might compare to other countries, it is not something that I think anyone of us would desire. The question is how do we change this? This just confirms the fact that we have insufficient medical training capacity in South Africa. I don’t think we need to spend too much time on it. I think that the information is something worth reflecting on.

So there are currently no accredited private medical training faculties in South Africa yet the number of youngsters that would love to study medicine is growing. You know
all the universities speak about how oversubscribed their posts are in terms of medical school. We have so many youngsters going offshore if they have the means, and a lot of them that just don’t have the means and are therefore not being educated in medicine in South Africa. At the same time if we look and take examples in other countries, other countries are very embracive of attracting private capital for medical education. the one extreme you have got Columbia with, looking at Barry to see if he can guide me on numbers, but Columbia has got crazy amounts of private medical schools and that is not what we are aspiring to, but just looking at India, we have got 50% of medical graduates coming out of private medical schools and a high calibre of medical graduates. Totally appropriate that you regulate the standard of education, that is a given. It is just, is it appropriate to attract private capital, be it local, be it foreign? In Brazil more than half of medical schools are private and the way I also get my mind around that is, I don’t think anyone questions the calibre of a Harvard University or a Yale University. Those are private medical schools. So we think that a critical issue to access, absolutely critical issue to access and to competition is this issue of doctors.

You will also note that we restrict the number of foreign practitioners that we bring in. There are a couple of regulatory hurdles, and if you have any questions I understand that Anthony is willing to take them. What I wanted to share with you is in the context of what I have just presented, we have a quota, we have a limit on the number of
foreign doctors that can work in South Africa, and this is a document, this is the Department of Health’s response to the healthcare inquiry, where we say the current national policy is to limit the recruitment of foreign doctors to a maximum of 6%, and just reflecting on that Lesotho example, as you walk through that Lesotho Hospital, it is doctors from all walks of life and a myriad of different countries, developed and emerging, and the question is, is there a way in which we can be more embracive of this issue with respect to doctors?

So, Chair, obviously you have questioned the topic on the employment of doctors. You cannot obviously have this discussion in isolation of the realities. So as much as we would like to do that, the realities are what the realities are, but happy to debate the benefits, but the primary benefits I want to raise with you is exactly like the Lesotho model. We have got other examples in emerging markets, specifically in Brazil. Brazil has two players in the lower cost element of the market, offering really attractive services at affordable prices. These are Health Maintenance Organisations, HMOs. The two players are called [Amil] and the second one is Intermédica, and basically these are parties that own the primary care, the pathology, have all the medical records, have secondary care specialists, and they basically collapse the profitability motive across the spectrum, and take the profit at the funding side, at the HMO side, basically keeping people healthy and out of the system.
So that is not in Netcare’s best interest given our business model here, but if you want to speak about what are the innovative ideas that are relevant to an emerging market such as South Africa, with the realities we have here today, those are some of the thoughts that we should be exploring.

I would like to hand over to Anthony, at this stage.

MR NORTON Chair, is now a convenient time to continue or would you like a short break?

JUSTICE NGCOBO You are almost done. Shall we considering then take a break once you are done?

MR NORTON That’s fine, Chair.

JUSTICE NGCOBO Unless it is an indirect request for a short break. You know sometimes it is a question in the form of a request.

MR NORTON No, thank you, Chair. I think I can manage, thank you.

JUSTICE NGCOBO Okay, very well.

MR NORTON Chair, I am going to be brief with these slides and I don’t intend to belabour this section. In the initial statement of issues, the HMI had raised regulatory
issues and had raised are there any unintended consequences of the current regulatory
regime which distort competition or impact on efficiencies, and we would just like to
highlight a couple of very brief examples of this, which we think that the panel may
wish to consider.

Chair, the first one deals with the Health Professions Council. Now, obviously this is a
very important institution in the sense that it regulates a very important set of
stakeholders, doctors in particular, and the reason why this is particularly relevant as
far as hospitals are concerned is the following, you will be aware that the Minister
appointed a task team last year to look into issues of maladministration at the Health
Professions Council, and there were a series of fairly damning findings about the
current operation of the Health Professions Council. Why is that relevant to the panel?
It is relevant in three important respects. The first is an issue of patient quality and
patient safety. Obviously the Health Professions Council fulfils an extremely
important role in oversight of doctors in particular, and gives the public confidence that
if there are issues and complaints that those will be attended to quickly and efficiently.
That is not happening. Secondly there is a lot of frustration from a doctor point of view
because if these complaints drag on indefinitely that also causes a lot of frustration
from a doctors point of view. Secondly foreign registration of doctors, if you are a
doctor with foreign qualifications and you want to work in South Africa that
registration has to be approved by the Health Professions Council. There are significant delays in that process. There are some reports which indicate both in relation to foreign nurses and foreign doctors two to ten years for registration. Obviously in the context, as Melanie has indicated where we have a shortage of doctors, that impacts on capacity, that impacts on competitiveness. So that is obviously a third very important aspect. The third is the ability of hospital groups and other players in the healthcare sector to offer innovative products. Melanie raised the example of Netcare wanted to roll out that mammography unit to previously disadvantaged areas. They had to employ a radiographer in order to do that. There were a number of interactions with the Health Professions Council in an attempt to get permission. Ultimately they gave up. That unit has now been donated to the Provincial Health Department. These are all examples of where regulatory inefficiency inhibits competition and it inhibits the ability of low cost models. The last point, and I think this is particularly relevant to some of the issues, Chair that you and the panel may consider later on in the process, some of the stakeholders have suggested that you may want to consider additional regulation, and there have been suggestions that private hospitals are under regulated rather than overregulated. I think one of the questions that the panel will have to consider is, do we have the regulatory capacity? Some of the key institutions in this country which are charged with very important
regulatory oversight plainly have failings. I think the question that the panel will need
to consider is, it is very, very important if you grant additional regulation and
additional regulatory oversight that there is the capacity and skills to deliver because
otherwise you have the inverse, it actually impacts on the proper performance of the
market. So we would just suggest, Chair that that’s an important issue for the panel to
consider, going forward.

Chair, briefly on nurses. As Melanie has indicated we also have a shortage of nurses in
South Africa.

**JUSTICE NGCOBO** You raise one matter which I think is relevant in the context that
you have just raised. If you look at the National Health Act it made provision, at least
for no less than ten regulatory bodies, National Provincial District, National Health
Research Ethics, Office of Health, Standards Compliance, Health Standards
Compliance Board, Ombudsman, I think they are called Ombuds, Forum for Statutory
Health Professionals, National Consultative Health Forum. Now, all of these bodies
are provided for in just one statute as I understand it, and it simply raises the question
of how do all of these regulatory bodies function, how does one coordinate their
functions so as to make sure that they function efficiently? One of the submissions that
were made to us when you ask this body about why haven’t you done this, they will
say, no, we are waiting for that other body, it is not our function, we are waiting for that body to do it and then once they have done it then we can perform our ... So it has a potential to result in some inefficiency if you have more of these bodies.

**MR NORTON** Chair, we would absolutely agree with your point and I think it is one of the issues that I am sure the panel will grapple with over the next few sessions is, is regulation a solution to some of the issues that have been identified by various stakeholders in this process. Because it comes with certain risks of its own, this plethora of bodies, overlap of functions and capacity and skills to discharge the mandate.

**JUSTICE NGCOBO** Or whether you need just one body that can take responsibility for all of these regulatory functions, which will be properly resolved, properly staffed so as to carry out its functions more efficiently, than have a number of bodies dealing with various aspects of the healthcare sector. Sorry I interrupted you.

**MR NORTON** No, thank you, Chair. Chair, we are just briefly discussing the issue of the shortage of nurses in South Africa, and I think this is a relatively well accepted fact, I don’t think there is a great of deal of dispute about it. Why is this particularly relevant in the hospitals? Well, it is relevant because of the cost component. So nurses in the Netcare context account for approximately 70% of the day to day operating costs
and 40% of the overall costs. So nursing is the key cost component as far as the operation of Netcare Hospitals are concerned, and obviously if there are shortages of nurses, that obviously impacts on costs. So you will see from this diagram that about 58% of nurses in South Africa are above the age of 40. Now, that is obviously a bit of a concern when it comes to new nurses and what is going to replace them.

Chair, Ms da Costa, in her presentation indicated that Netcare has got five nursing campuses and they train 3,400 students, but one of the difficulties that they have encountered is getting permission from the Nursing Council to train additional nurses. This obviously is very relevant to capacity and bringing on additional nursing staff because that is so critically related to cost. In terms of the Nursing Act, section 42, Chair, you can’t run a nursing college without accreditation from the Nursing Council. The regulations go further, and even a course, a particular course that you want to train, each and every course requires its own accreditation. What happened is, pursuant to the Nursing Act, regulations were passed in relation to accreditation, and it is regulation 173, in particular, and what paragraph 7 of that says is that every time you want to add additional learners to an existing institution, you are require additional accreditation. So by way of example, in KwaZulu-Natal, Netcare wanted to add additional learners to its nursing institution, and it has been engaging since 2009 with the Nursing Council to get permission to add those additional nurses, and that
permission still hasn’t been forthcoming. So this is part of the regulatory challenge that hospitals like Netcare face in trying to increase and supplement the number of nurses, and there are certain regulatory inefficiencies in the existing system which unfortunately are hampering those efforts.

There are also significant restrictions on the employment of foreign nurses. Now, because of the nursing shortages in South Africa some of the hospital groups, and I don’t think Netcare is alone in this, I think Mediclinic has likewise indicated to you yesterday that they sought to see whether they could employ foreign nurses, but there is a significant bureaucratic rigmarole involved in employing foreign nurses. Now, I don’t think for a minute that we would suggest that there shouldn’t be oversight, that there shouldn’t be regulation, that there shouldn’t be a process for ensuring that if you are bringing foreign nurses into the country that they suitably qualified and that they don’t have a poor nursing history, but unfortunately the current process, and there have been these guidelines published by the Nursing Council for registration of foreign nurses, are incredibly burdensome. You are required, by way of example, a letter of support from The Department of Health if you want to bring in foreign nurses. You require their credentials to be assessed by the South African Credentials Association. There are a range of other requirements, regulatory requirements, including writing exams in South Africa even if you are a highly qualified nurse in other countries, and
all of these things effectively impair the ability to bring in additional nursing capacity into the country.

Again, Chair, we think that the Department of Health has recognised these issues and I don’t think that there is a great deal of difference of view between the private sector actors and the Department on this issue, but there needs to be greater capacity building initiatives, and I guess the question really for the panel to consider is, are there ways of streamlining or making the current bureaucratic process more efficient? We are not suggesting that there shouldn’t be one, but the current process really impairs and impedes the ability of hospital groups to bring in additional nursing and capacity.

Chair, I want to then move on to surgical’s, medical devices and medicines. As you have heard from Ms da Costa’s presentation, surgical’s, medical devices account for a significant proportion of medical scheme spend at Netcare, somewhere between 25 to 30%. Medicines are charged at the single exit price in terms of the Medicines Related Substances Act, so there is no mark up, it is simply charged at the single exit price, and similarly medical devices and surgical’s are charged at the cost price, net acquisition price. What Netcare did in 2010, they got a whole lot of data from their UK operations, and they compared some of the prices on medicines that their UK subsidiary was purchasing against the prices of the same medicines that they were
purchasing in South Africa, to have a look at what the potential cost differentials were. Now, if you look at this slide you will see that there are significant cost differentials. I mean, in some instances up to 1,000%. Now, that may be a function of a variety of factors, but from a regulatory perspective the question that we have always asked ourselves is, is there a way of bringing down drug prices in South Africa through, for example, parallel importation? If there are equivalent drugs, the same patented drug which is much cheaper in other countries, could you simply parallel import the product into South Africa, and thereby reduce drug costs significantly in South Africa? The difficulty unfortunately, again, is a regulatory one. Section 14 of the Medicines Act says that you may not sell a drug in South African unless it has been registered, you also may not parallel import a drug, in terms of section 15 (c) of the Medicines Act, unless the Minister has prescribed certain conditions relating to parallel importation of the drugs. Now, I think that provision was intended to be an emergency provision, you know, for particular instances where drugs were very expensive in South Africa and emergency circumstances warranted the Minister prescribing those particular conditions, but the difficulty is that the Medicines Control Council has published certain guidelines for parallel importation, and what they have suggested is that you can, in terms of section 15 (c), apply to the Minister for a permit to parallel import drugs., but, Chair, we are not certain that from a legal perspective the guidelines
actually accord with the legislation, because the legislation seems to envisage the
Minister actually prescribing conditions, and that doesn’t appear at this case to have
been the case across the board. So that would be a regulatory inhibition to parallel
importation where there are significantly cheaper drugs which could be brought into
the country.

Chair, I want to touch briefly on the topic of hospital licensing because I think that has
been an issue that you have raised a number of questions on in the last few days, and in
fact as recently as yesterday, I think you raised a question with our colleagues at
Mediclinic about the regulatory regime around hospital licensing and where do we
currently stand as far as that’s concerned.

So, under the existing regulations as they are being applied by the various provincial
departments, you not only require a licence to open a new hospital, but you require a
licence if you want to add on to that hospital, and even if you want to convert existing
beds. So by way of example, let’s say you have got a licence for 100 paediatric beds at
a particular hospital, you find that you are not using all of those beds for paediatric
purposes and you want to change some of those to orthopaedic beds because there is
now an increased demand, you can’t do that without permission, and the same
regulatory process and the same regulatory time period applies. Chair, we have
provided you with a very detailed list, in annexure C to our regulatory paper, which sets out all the various instances where Netcare hospitals have applied for permission and for licences to extend beds, to change beds, etc. and we have given you indications of the extensive time periods that are sometimes associated with that., sometimes a year to two years, sometimes three years with no response, sometimes no feedback at all. In other instances you get a response which simply says from the particular government department, you can convert eight beds, but not the full 20 beds that you have applied for, no reasons are given.

In other instances for new hospital builds, lengthy periods in some cases, a year to two years with no response and then all of a sudden the response is your application is declined, for no apparent reason. Chair, I don’t think it is controversial to say and the Department of Health I think has quite fairly acknowledged, that there is a fragmented approach to hospital licensing in this country. Each provincial department, some apply the same regulations, some don’t and their application of those regulations is quite different.

Chair, you posed, I think, the crucial question in the last few days which goes to two issues. The first question you posed is, are the existing regulations that the Provincial Health Departments are applying, are they still properly in force? I think the question
that you posed is because of the repeal of certain provisions of the 1977 Health Act which came fully into force in 2012, what does that mean for the existing regulations that the current departments are applying, and have those regulations effectively fallen away as a consequence of the repeal of the previous Health Act in 2012? Chair, we have got a provisional answer which I think may assist you, I am not going to suggest that it is a complete answer, but I think you posed this question to Mediclinic yesterday, and I would like to have a stab very briefly at trying to explain how we see it. So under the Health Act of 1977, the Minister passed various regulations, one of them, which was regulation 158, which I think the panel is fairly familiar with, and this is the regulation which the Gauteng Department, the Eastern Cape and KwaZulu-Natal apply in relation to hospital licensing. Certain provisions of the 1977 Act were assigned to the various provinces in 1994, and that included section 44 of the old Health Act which provided for regulation of private hospitals. As a consequence of that assignment, a number of the provinces then just simply adopted those regulations 158, so Gauteng did that, the Eastern Cape and KwaZulu-Natal. The Western Cape, as you heard in your session with them did something different. They used the powers under section 44, the assigned powers, and they effectively enacted their own regulations, which is regulation 187, Chair, and they repealed the previous provisions of 158. The Free State has done something completely different. So in 2014 they have
used the provincial legislation, provincial health legislation, and they have enacted their own regulations and they have repealed the previous 158. So they have now gone a different route and used the Provincial Health Act to introduce their own licensing regulations. The question then becomes, well when the provisions of the 1977 Act were totally repealed in 2012, what happened? I think, Chair, one potential answer that you may wish to consider in this regard is, the provisions of section 93 (2) of the National Health Act which effectively introduced a savings provision, and what the savings provision said was that if you had effectively done something which could be done under the new Act, that effectively could be saved by virtue of that savings provision. Now, it is a question of legal interpretation, and I am not going to suggest to you today that we have got a definitive answer on this, but potentially that savings provision may mean that the existing regulations around hospital licensing are still lawful and are still able to be implemented. I think, Chair, one question that you did pose, which I think is definitive, is whether the health departments of the various provinces can amend the current regulatory regime, and the answer is that unless they are doing it under the Provincial Health Acts, they can’t, because the previous power to do so was repealed in 2012. So effectively where we sit today is we have numerous provinces, some of which apply the old regulation 158, the Western Cape applies its own 187, the Free State has now imposed its own regulations pursuant to the Provincial
Health Act, and very recently, in fact the Free State had a moratorium on private hospital licences which was only lifted in the last two weeks. So each of the provinces is applying a different way of approaching this issue and obviously that leads to considerable inefficiencies in the current system of hospital licensing.

Justice Ngcobo

There is an old case that I can remember, DVB, I think it was, which may provide some answer as to whether or not they have the power to repeal legislation that was assigned. It would provide an answer, but it is a fairly old case, I think it is 1999, if I remember the case very well. It had to deal with the North West Proclamation 293, I think it is. I can’t recall the full name.

Mr Norton

Chair, I don’t have an answer, offhand, but I will defer to my much more learned colleagues, Mr Unterhalter and other counsel on that point. I think, Chair, in short, our submissions to the panel are really that something has to be done about this, because there is not a unified system throughout the country. Apart from the Western Cape, the Western Cape is the only health department whose regulations provide for time periods for processing hospital applications. None of the other health departments have specific time periods built in for processing hospital applications, and that is a function of the wording of the old regulation 158. Gauteng did try and introduce new regulations in 2015, but withdrew those draft regulations because they
realised they didn’t have the power to enact amendments to the existing regulations so those have been withdrawn. So we sit in this unfortunate situation of a fragmented approach, and apart from the Western Cape no time periods for assessing applications, often no reasons given, and a failure really to observe general provisions of administrative provisions under PAJA.

Chair, in conclusion, we think there are some significant inefficiencies in the current regulatory regime, whether it is in terms of the Health Professions Council, whether it is the way in which the Nursing Council operates, whether it is in the way in which the current hospital licensing regime currently operates, which we think the panel would need to consider and take into account.

Chair, there is one final slide from my side, and I realise that this is very early days in this debate, and we certainly don’t want to pre-empt anything that the panel will be considering in this issue, but we did think it was worth just two minutes on this particular issue. Chair, some of the stakeholders that have appeared before you have suggested that the panel may wish to consider some form of price regulation in the private healthcare sector, whether that is in relation to hospitals, whether that is in relation to doctors or across the board. We just thought that we would maybe make some very preliminary submissions and give you some thoughts in that regard, and we
have included just one indication from the UK private healthcare inquiry which obviously preceded your own by a year or so, and we think that there are a couple of issues that the panel may just wish to consider in regard to this issue. The first, Chair, and I think this was something that the UK Commission acknowledged in its inquiry, is that before one would go down this route, the panel would have to be convinced that there was a strong and comprehensive body of evidence of market abuse. In other words you would need to be satisfied that there is a comprehensive body of evidence of anti-competitive conduct, whether that be excessive pricing, other forms of exclusionary conduct, other forms of anti-competitive abusive behaviour which would warrant some form of remedy of this kind. So that would be the first point of departure. The second, Chair, is that you would need to be satisfied that there are no other remedial measures that would more than adequately cater for any anti-competitive issues that you identified. So again by way of example going back to the UK inquiry, one of the recommendations which Netcare would be supportive of, and which is being implemented in the UK, is that they said that there should be an independent body which gathers information from hospitals and clinicians which publishes outcomes so that members of the public and schemes and everybody else could be aware of clinical outcomes, etc. That was one of the key recommendations in the UK inquiry and that is certainly something along those lines we would be broadly
supportive of, Chair. So I think the second point would be the panel would just need to consider whether there are not, if you do identify any particular anti-competitive issues, are there other remedial measures or other steps which would address those. The third point, Chair, and I guess this is perhaps a point that I have alluded to already, we already have significant difficulties in certain of our regulatory oversight functions in South Africa already, and I have already alluded to certain instances, the Health Professions Council, the Nursing Council, the licensing issues, to add more regulation and additional regulatory bodies where the existing regulatory system is not functioning optimally and effectively would be something that we think the panel would need to consider very, very carefully. Lastly, Chair, and I think this is probably a bit of a point that is in a sense comes from a competition lawyer, intrinsically, but our competition bodies and the Competition Tribunal, in particular, has suggested the price regulation should be an option of last resort in a competition context. Chair, you might just want to look at the judgement of the Competition Tribunal in the Mittal excessive pricing case, and the previous chairperson of the Competition Tribunal, David Lewis, may have made some remarks in that context.

Chair, thank you very much for your patience. I don’t have anything further to add. Chair, there is nothing further from my side. I was just going to say that Mr Unterhalter has number of short submissions that I think he would like to make, on a
paper that we submitted, Chair, and I don’t know if now is an appropriate time or whether you would like to take a break?

JUSTICE NGCOBO It would have been preferable if you had also drawn attention to those countries where a regulation has been implemented, and perhaps successfully, if there are any of those countries, but I do understand that this is just your preliminary reaction.

MR NORTON Absolutely, Chair. I think there is a much more comprehensive and detailed debate that needs to happen, but we just wanted to give you an initial flavour of some of our preliminary thoughts on this topic, just because it had been raised by some of the other stakeholders, and we didn’t want it to go unsaid at this stage, Chair.

JUSTICE NGCOBO You just wanted to flag the point.

MR NORTON Correct.

JUSTICE NGCOBO In your enthusiasm to flag the point you may well have put the bar probably too high, though, that it must be resorted as a last resort.

MR NORTON Chair, I think there will obviously be differences of perspective on that, but I think perhaps we can develop our thinking on that in due course. We just wanted to give you some initial thoughts in that regard. Thank you, Chair.
JUSTICE NGCOBO Mr Unterhalter.

ADV UNTERHALTER We are just still waiting for the slide pack to materialise because there is a first slide I would like to show you.

JUSTICE NGCOBO The issues that you are going to raise, though, they are foreshadowed, are they not?

ADV UNTERHALTER No they are entirely shadowed. Perhaps I should, while we are waiting, just indicate what it is that this last section wishes to do. We have submitted to you a fairly extensive paper on the constitutional issues and the relationship between your inquiry and section 27. We are not going to engage again in that legal treaties in any detail.

What we really wanted to do was rather to try and situate the inquiry that you are engaged upon, in relation to section 27 and how it relates to an inquiry of this kind, under the Competition Act, and we want to do it largely in a schematic way, so let me just try and get to the first slide.

I want to spend some of my time dealing with this schematic, because this, I think, captures for us how you will think about or might wish to think about where your inquiry sits within the scheme of both regulation and constitutional obligation.
So we start at the point of departure, which is section 27 and the rights of access to healthcare. Now, as we have indicated in our paper, and as is well known, that is a socio economic right which burdens the state with an obligation, in the first place, to take reasonable measures progressively to achieve access rights., and that is where the positive obligation rests, and it is to take both legislative and other measures.

Now, the measures that the state has taken are numerous, but for the purposes of your inquiry, the one that is most relevant, is the Competition Act, because this inquiry engages a market wide inquiry under the Competition Act. We would understand and do understand the Competition Act to be one such response, at least in the healthcare environment, to the section 27 obligation, because what it is concerned with is to examine whether there are market distortions, restrictions and preventions of competition that may have an impact on access to health, but although that inquiry is vital and, for the purposes of a marketing inquiry, it is distinctive, by reason of the fact that it is a market wide investigation, rather than a conduct specific investigation, which would be what one would be looking at if one was considering specific restrictive practises, as one would, in other parts of the Act, though it would be a market wide inquiry, it is nevertheless restricted by this consideration, which is that one is concerned with the question of access as markets can deliver that access, and this
is where there is potentially great scope for expanding this inquiry beyond what it can properly accommodate within the scheme of the Competition Act itself.

So I think, Chair, as you, yourself have indicated in announcing this inquiry, there is a fundamental distinction between the way in which a market may be said to work and the kinds of outcomes a market may yield up for the purposes of access, and other kinds of legislative or executive intervention which will seek to secure outcomes that are relevant for access, but are not market based outcomes.

So just to make this point, because we do think it is fundamental to the inquiry, under section 27 in the positive obligations that rest on the state, you can deploy public resources to secure access to health, and that is largely what is captured by the public health system. You can have regulatory interventions to secure access. One such regulatory intervention is the Competition Act, and the Competition Act is concerned with making sure that markets are working properly, and in so far as they do work properly, how market based access is possible. There are, of course, other forms of intervention which may do different kinds of things. They may seek to regulate the market, as we have seen in a number of ways, and they may also seek to ensure that the kinds of outcomes that markets might yield up should, for various reasons, be changed
or in some way mitigated through regulatory intervention.

I am going to touch very briefly on solvency. There are a few slides here, but I am going to gloss over them and you can come back to me on any questions.

The long and the short of the solvency issue is that schemes are required to hold 25% of gross contributions in reserves. It is widely acknowledged that this is an incredibly blunt and immature means of a solvency protection for medical schemes. It doesn’t take in to account any particular risk aspects of the scheme. It doesn’t take in to account size, risk profile, variations in surplus or deficits, it doesn’t take in to account reinsurance. It means that some schemes hold more than they should be holding, from an economic capital point of view, and some schemes are holding less than they should be, from an economic capital point of view. What it meant, particularly in the first two years of the decade 2000 to 2004 when schemes were required by the Act to build solvency up to 25% was an extra burden on scheme contributions so that they could build up the solvency. If you look at the operating result of medical schemes over that period you can see schemes making much higher surpluses than in the years following.

So [indistinct 1.58.00] we sit with almost R50 billion in accumulated funds of medical schemes with incredibly tight investment regulations, and that money is sitting there
essentially in cash for no other reason than to meet the requirements of the Act at the 25%.

One other important aspect of the solvency that I want to touch on is that schemes can only build solvency through operating surpluses, in other words, the difference between the money that they collect through contributions and the outgo that they must pay through expenses and claims. This is unlike, say, an insurance company, a general insurance company or a life insurance company who, to raise solvency capital or operating capital, can go to the market and either raise a loan or raise equity finance, etc. Medical schemes aren’t able to do that, therefore the only way they can build solvency if they are required to do so under the Act is to increase contributions. This obviously penalises growing schemes and counter intuitively gives schemes that are shrinking, who may be in decline, a higher solvency ratio. So while they may look good from a solvency perspective, that doesn’t necessarily indicate their financial health. It also has the effect of being a barrier at entry to new schemes. As I said, you can’t go to the market and raise capital. You are required by law over a five year period to get to the 25% and that can only happen through inflated contributions. All of that said, that gets us to where we are. We recognise Circular 68 of 2015. The Council has published a discussion document on risk based capital framework. Unfortunately it comes 16 years into the process of schemes having to get up to the
25%, but we hope that that will have an improvement of the way that schemes are measured on statutory solvency in the future.

Chair, I think the main focus of ...  

*JUSTICE NGCOBO*  There are no exceptions to this amount, to this percentage, is it?  

There is no exemption, there is no …  

*MR CHILDS*  No to my knowledge there are no exemptions. There are schemes that don’t meet the 25% and I think you heard from one or two schemes that presented that the Council asks for business plans on how they are going to get to the 25%.

*JUSTICE NGCOBO*  If you can’t demonstrate that you can’t enter, is it?  

*MR CHILDS*  You can’t enter, is that the question? Yes, so if you want to bring a new scheme to the market which there haven’t really been any, particularly any open schemes in the last, in recent memory, you would have to bring a business plan that would demonstrate to the Council how you are going to reach the 25% in the prescribed period.

Anti-selection and adverse selection. This is also something that you would have heard about from a couple of different stakeholders, and I would like very much to present the data and evidence to you on this point.
[indistinct 2.01] rating preclude schemes from turning applicant members away and they also preclude schemes from charging patients different premiums based on their risk profile. Premiums can only be differentiated, based on the benefits that are offered, so different options have different premiums. Schemes can offer different premiums for a principal member, an adult dependant and a child dependant and they can offer different premiums for income levels to facilitate income cross subsidy, but no other differentiation is allowed. This creates an incentive for younger and healthier people to join only when they are older or when they need cover. For example, in childbirth, that is a typical example, anti-selective behaviour leads to deteriorating risk profiles within medical schemes and for the industry, as a whole. It leads to higher costs for beneficiaries of all schemes. This is given the term, the much maligned term, the actuarial debt spiral, which is a little dramatic. What we have seen happening, actually, over the period is what we might rephrase an actuarial death trickle. It is not a cataclysmic effect, it is a small effect every year, but on a cumulative basis over an extended period of time it is extremely significant.

You will have seen a graph similar to this before, but looking at the shape of the South African population versus the age distribution of medical scheme members, the shapes are quite different. There is a big drop off in coverage amongst medical scheme members in early adulthood. This is often when children drop off as child dependants
on their parent’s medical scheme and they don’t immediately re-enter the medical scheme market on their own, again, until they perceive the need for cover.

It is useful [indistinct 2.03] to compare to the South African population as a whole, which is quite skewed to the left for other reasons, but also to compare it to the population above the tax threshold. So there is a little bit of a dip there. Again, these are people in households, looking at the income levels at a household, so there is this little bit of a dip into early adulthood which again is as the child leaves the household and starts to earn on his or her own, he is not necessarily at that kind of income level, but it is very clear that between, say, 20 and 35 and 39 there is a significant shortfall in the medical scheme membership that we would expect, because it is not compulsory, and a significant higher prevalence of medical scheme members in the tail above the age of 40.

What I don’t think you have seen before, Chair and panel, are that this is not a once off effect. So I know Dr von Gent asked this question, if it is a once off effect of anti-selection then why would we argue that it drives inflation? Well, it is not a once off effect. If I show you the graph on the right hand side first, this data is collected from Council for Medical Schemes statutory return data which contains the age distribution of beneficiaries for all schemes by a scheme, it also includes the gender mix, and we
have been able to collate this data over the ten year period 2002 to 2012. What you can see, if I built the slide on an incremental basis, you would see that every year the distribution changes little bit by little bit.

The graph on the left that I have shown strips out the interim years and just shows 2002 to 2012 and the kinds of things that you see are a higher proportion of under one’s. I don’t have it in these slides, but if you look at the cost code of the per life [indistinct 2.04] cost by age, under one’s cost medical schemes a lot of money because neonates cost a lot of money, etc. So those patients cost medical schemes a large amount. Then the tail of the distribution again you find that looking at 2012 the tail is heavier, more all the people in the system than there were in 2002.

So the data suggests, and I would stress the point that this is not anecdotal data, this is systematic data looking at the industry in aggregate, obviously it will be experienced differently by different medical schemes, but looking at the industry in aggregate, there is an incremental effect every year of this aging and anti-selective process.

We can directly then quantify the impact of this change in demographics over the year, overall taking in to account demographics and a burden of disease measure, which I will describe to you in a moment, we calculated that this has the impact of a 2% per annum increase in the cost of medical scheme coverage. The way that we did this was
to look at the PMB cost curve which is publically available, by age, so we know that healthcare costs vary by age, we applied those different age profiles to that PMB cost curve every year and we can quantify the effect. The aging effect on its own at an industry level is about 1.3%. On top of that we were able to use a publically available risk equalisation fund data which was unfortunately only published to 2010 in the public domain in the detail that we would need to do the numbers, and what it allows us to do then is quantify the burden of disease impact over and above aging, and that gives us another .6% per annum. It actually gives us a floor estimate of the change in the burden of disease, because we’re, by definition, only measuring the change in chronic incidents of the CDL conditions and not measuring, we don’t have publicly available data for the industry for the non-CDL conditions. So that gives us a 2% floor estimate of what has been termed the demand side drivers of healthcare cost. So that means everything else equal, if nothing else changed and all we were able to witness is the changing demographics and the changing burden of disease over the period, we would be talking about a 2% impact per annum.

**DR VON GENT** [indistinct 2.07] clarification, it is aging as such or is this aging of the population because, or included in anti-selection?

**MR CHILDS** It is aging of the population as such with anti-selection included in the
calculation, yes. So there is natural aging and there is the effect of anti-selection over and above that.

Perhaps before I leave this slide, the point I want to make is that if you look only at the average age of the medical scheme population, it hasn’t changed that much. So this is the green line in the graph and it bumps around a little bit, but if you look over the period, it is a fairly stable number. We argue that you can’t look at the average age only because the cost impact of aging or change in the age distribution depends on just that, the distribution, not the average age. The population could stay 35 years old, but could expand in the under one’s and in the over 65’s and costs would go up significantly. So you have to look a little bit deeper than just looking at the average age.

So to touch on [indistinct 2.08] in previous discussions in the last couple of weeks, there is a question of causality in correlation. We can see this, but do we have a case study? Can we show, can we construct an environment against which to test this hypothesis that there is anti-selection? As it happens we have as close to a case study as we can derive right in the industry.

If we consider the change in contribution increases for restricted schemes compared to open medical schemes, over a 13 year period we see a stark difference. The graph you
have in front of you is indexed, just to remove the differences in absolute levels which are driven by other factors, for instance differences in administration costs, etc. but if you look at the rate of increase of the premiums of restricted medical schemes, they have been going up by 2% per annum less than open medical schemes over the period. On a cumulative basis over 13 years that amounts to about a 30% difference. If we considered the impact on the industry, as a whole, restricted and open medical schemes that would get us to about a 15% impact, in other words, contributions are 15% higher than they could be under a mandatory environment regime, which gets us to about a R20 billion difference in terms of current contribution levels off the current base.

Thank you, Chair.

JUSTICE NGCOBO Thank you Mr Childs.

MS DA COSTA Thank you Barry. So, Chair, we are now just going to move on to a couple of slides just talking to the issue of doctors. So just expanding on the topic of the shortage of doctors, what you see in front of you now is an analysis done by Iconic in 2015 that just looks at the number of practitioners actually operating in South Africa, so not just registered with the Medical Council, but actually to the best of their knowledge from the analysis they did, present in South Africa.
So the 60 in and of itself looks low, that is 60 per 100,000 citizens, but [indistinct 2.10] lies a lot of information and if you look at just GPs alone, the public sector has a ratio of 25 GPs per 100,000 population, the private sector has 92. So what we want to stress in that is that even the private sector fares very poorly in terms of the number of doctors versus other comparators, but obviously the situation in the public sector is absolutely dire. This goes to the complete understanding of the impact on competition because it effects competition in healthcare in absolutely every single level. Just to put this in context in terms of doctor numbers, Brazil, for example, which has half of South Africa’s burden of disease has 189 doctors per 100,000 population. Just to add another statistic which I think is important on this, if we look at the Netcare doctors, the doctors that are operating out of Netcare facilities, the average age is anywhere between 50 and 55, so just bear that in mind too when we consider the number of doctors in our country, is just the aging population of the doctors. If we look at specialists you can see that that situation looks infinitely worse. I would like to just also split out the private versus public sector because that is critical. The number of specialists in the private sector per 100,000 population is 86. So if you run your 86 across you can see exactly how it ranks, it does not rank well internationally, but the situation in the public sector is heartbreaking at 5.6 specialists per 100,000 population.
So I just want to go back quickly. So when you consider the shortage of specialists in the country, there were some questions posed in the last two days about if we had the opportunity of taking one speciality versus another speciality, and giving a particular doctor admitting privileges, which one would you choose? Across our portfolio any one time we have a pretty good sense of the types of specialities that we are short of, where there is a demand either because there isn’t that speciality at a hospital, or because their waiting list for the specialists that already have consulting rooms on site is very high. So we would try and source those doctors that are in short supply. It goes without saying, given the fact that we have such few neurosurgeons in the country, for example, or neurologists, that we would take a neurologist before, for example, a dermatologist, it also goes to levels of care, appropriateness of care, etc., but I just thought I would expand on that.

Now, this is the burden of disease. We don’t need to expand on it. There is a lot of research on this. South Africa fares badly relative to developed countries and I think that that is perhaps expected. I think what is heartbreaking is when we see how South Africa fares to other emerging markets and specifically the BRIC countries.

So we are all on the same page with respect to the shortage of doctors. The Department of Health has absolutely no difference of opinion. They recognise the
many challenges that exist with respect to human resources, not just in doctor training, but across the healthcare spectrum, and they go so far as to say that they too understand that doctors are mobile. So this goes to any regulation that is implemented and any thought process around future regulation. We can ill afford not attracting more doctors, not attracting more youngsters to study medicine in South Africa, or not attracting doctors to our shores from offshore. It is in my opinion that we should be doing everything we can in applying our mind on how it is that we could increase the number of doctors being trained or educated in South Africa.

This takes me to the next topic which is our training capacity. We have a very limited number of medical schools in South Africa. The training capacity has been increased slightly over the last few years, perhaps another 200 seats or so, but in short I think it is a fair statement that it has been stagnant now for several decades, notwithstanding what has happened to the population. I mean as I mentioned, the population has effectively doubled since the late 1970’s. So even, though, there has been aspiration to increase the number of graduates being educated, it is obviously more complex than that, otherwise we would have already done that. Obviously we have explored other alternatives outside of South Africa, specifically Cuba. That in itself is not a sufficient structural solution.
So as a result of not increasing the ratio of medical schools, the population ratio to medical schools has increased. If you look at this graph, specifically 2013 you can see that South Africa has basically a medical school to every 6.6 million population and how that might compare to other countries, it is not something that I think anyone of us would desire. The question is how do we change this? This just confirms the fact that we have insufficient medical training capacity in South Africa. I don’t think we need to spend too much time on it. I think that the information is something worth reflecting on.

So there are currently no accredited private medical training faculties in South Africa yet the number of youngsters that would love to study medicine is growing. You know all the universities speak about how oversubscribed their posts are in terms of medical school. We have so many youngsters going offshore if they have the means, and a lot of them that just don’t have the means and are therefore not being educated in medicine in South Africa. At the same time if we look and take examples in other countries, other countries are very embracive of attracting private capital for medical education. the one extreme you have got Columbia with, looking at Barry to see if he can guide me on numbers, but Columbia has got crazy amounts of private medical schools and that is not what we are aspiring to, but just looking at India, we have got 50% of medical graduates coming out of private medical schools and a high calibre of medical
graduates. Totally appropriate that you regulate the standard of education, that is a given. It is just, is it appropriate to attract private capital, be it local, be it foreign? In Brazil more than half of medical schools are private and the way I also get my mind around that is, I don’t think anyone questions the calibre of a Harvard University or a Yale University. Those are private medical schools. So we think that a critical issue to access, absolutely critical issue to access and to competition is this issue of doctors.

You will also note that we restrict the number of foreign practitioners that we bring in. There are a couple of regulatory hurdles, and if you have any questions I understand that Anthony is willing to take them. What I wanted to share with you is in the context of what I have just presented, we have a quota, we have a limit on the number of foreign doctors that can work in South Africa, and this is a document, this is the Department of Health’s response to the healthcare inquiry, where we say the current national policy is to limit the recruitment of foreign doctors to a maximum of 6%, and just reflecting on that Lesotho example, as you walk through that Lesotho Hospital, it is doctors from all walks of life and a myriad of different countries, developed and emerging, and the question is, is there a way in which we can be more embracive of this issue with respect to doctors?

So, Chair, obviously you have questioned the topic on the employment of doctors.
You cannot obviously have this discussion in isolation of the realities. So as much as we would like to do that, the realities are what the realities are, but happy to debate the benefits, but the primary benefits I want to raise with you is exactly like the Lesotho model. We have got other examples in emerging markets, specifically in Brazil. Brazil has two players in the lower cost element of the market, offering really attractive services at affordable prices. These are Health Maintenance Organisations, HMOs. The two players are called [Amil] and the second one is Intermédica, and basically these are parties that own the primary care, the pathology, have all the medical records, have secondary care specialists, and they basically collapse the profitability motive across the spectrum, and take the profit at the funding side, at the HMO side, basically keeping people healthy and out of the system.

So that is not in Netcare’s best interest given our business model here, but if you want to speak about what are the innovative ideas that are relevant to an emerging market such as South Africa, with the realities we have here today, those are some of the thoughts that we should be exploring.

I would like to hand over to Anthony, at this stage.

*MR NORTON* Chair, is now a convenient time to continue or would you like a short break?
JUSTICE NGCOBO  You are almost done. Shall we considering then take a break once you are done?

MR NORTON  That’s fine, Chair.

JUSTICE NGCOBO  Unless it is an indirect request for a short break. You know sometimes it is a question in the form of a request.

MR NORTON  No, thank you, Chair. I think I can manage, thank you.

JUSTICE NGCOBO  Okay, very well.

MR NORTON  Chair, I am going to be brief with these slides and I don’t intend to belabour this section. In the initial statement of issues, the HMI had raised regulatory issues and had raised are there any unintended consequences of the current regulatory regime which distort competition or impact on efficiencies, and we would just like to highlight a couple of very brief examples of this, which we think that the panel may wish to consider.

Chair, the first one deals with the Health Professions Council. Now, obviously this is a very important institution in the sense that it regulates a very important set of stakeholders, doctors in particular, and the reason why this is particularly relevant as far as hospitals are concerned is the following, you will be aware that the Minister
appointed a task team last year to look into issues of maladministration at the Health Professions Council, and there were a series of fairly damning findings about the current operation of the Health Professions Council. Why is that relevant to the panel? It is relevant in three important respects. The first is an issue of patient quality and patient safety. Obviously the Health Professions Council fulfils an extremely important role in oversight of doctors in particular, and gives the public confidence that if there are issues and complaints that those will be attended to quickly and efficiently. That is not happening. Secondly there is a lot of frustration from a doctor point of view because if these complaints drag on indefinitely that also causes a lot of frustration from a doctors point of view. Secondly foreign registration of doctors, if you are a doctor with foreign qualifications and you want to work in South Africa that registration has to be approved by the Health Professions Council. There are significant delays in that process. There are some reports which indicate both in relation to foreign nurses and foreign doctors two to ten years for registration. Obviously in the context, as Melanie has indicated where we have a shortage of doctors, that impacts on capacity, that impacts on competitiveness. So that is obviously a third very important aspect. The third is the ability of hospital groups and other players in the healthcare sector to offer innovative products. Melanie raised the example of Netcare wanted to roll out that mammography unit to previously
disadvantaged areas. They had to employ a radiographer in order to do that. There were a number of interactions with the Health Professions Council in an attempt to get permission. Ultimately they gave up. That unit has now been donated to the Provincial Health Department. These are all examples of where regulatory inefficiency inhibits competition and it inhibits the ability of low cost models. The last point, and I think this is particularly relevant to some of the issues, Chair that you and the panel may consider later on in the process, some of the stakeholders have suggested that you may want to consider additional regulation, and there have been suggestions that private hospitals are under regulated rather than overregulated. I think one of the questions that the panel will have to consider is, do we have the regulatory capacity? Some of the key institutions in this country which are charged with very important regulatory oversight plainly have failings. I think the question that the panel will need to consider is, it is very, very important if you grant additional regulation and additional regulatory oversight that there is the capacity and skills to deliver because otherwise you have the inverse, it actually impacts on the proper performance of the market. So we would just suggest, Chair that that’s an important issue for the panel to consider, going forward.

Chair, briefly on nurses. As Melanie has indicated we also have a shortage of nurses in South Africa.
JUSTICE NGCOBO  You raise one matter which I think is relevant in the context that you have just raised. If you look at the National Health Act it made provision, at least for no less than ten regulatory bodies, National Provincial District, National Health Research Ethics, Office of Health, Standards Compliance, Health Standards Compliance Board, Ombudsman, I think they are called Ombuds, Forum for Statutory Health Professionals, National Consultative Health Forum. Now, all of these bodies are provided for in just one statute as I understand it, and it simply raises the question of how do all of these regulatory bodies function, how does one coordinate their functions so as to make sure that they function efficiently? One of the submissions that were made to us when you ask this body about why haven’t you done this, they will say, no, we are waiting for that other body, it is not our function, we are waiting for that body to do it and then once they have done it then we can perform our ... So it has a potential to result in some inefficiency if you have more of these bodies.

MR NORTON  Chair, we would absolutely agree with your point and I think it is one of the issues that I am sure the panel will grapple with over the next few sessions is, is regulation a solution to some of the issues that have been identified by various stakeholders in this process. Because it comes with certain risks of its own, this plethora of bodies, overlap of functions and capacity and skills to discharge the mandate.
JUSTICE NGCOBO  Or whether you need just one body that can take responsibility for all of these regulatory functions, which will be properly resolved, properly staffed so as to carry out its functions more efficiently, than have a number of bodies dealing with various aspects of the healthcare sector. Sorry I interrupted you.

MR NORTON  No, thank you, Chair. Chair, we are just briefly discussing the issue of the shortage of nurses in South Africa, and I think this is a relatively well accepted fact, I don’t think there is a great of deal of dispute about it. Why is this particularly relevant in the hospitals? Well, it is relevant because of the cost component. So nurses in the Netcare context account for approximately 70% of the day to day operating costs and 40% of the overall costs. So nursing is the key cost component as far as the operation of Netcare Hospitals are concerned, and obviously if there are shortages of nurses, that obviously impacts on costs. So you will see from this diagram that about 58% of nurses in South Africa are above the age of 40. Now, that is obviously a bit of a concern when it comes to new nurses and what is going to replace them.

Chair, Ms da Costa, in her presentation indicated that Netcare has got five nursing campuses and they train 3,400 students, but one of the difficulties that they have encountered is getting permission from the Nursing Council to train additional nurses. This obviously is very relevant to capacity and bringing on additional nursing staff
because that is so critically related to cost. In terms of the Nursing Act, section 42, Chair, you can’t run a nursing college without accreditation from the Nursing Council. The regulations go further, and even a course, a particular course that you want to train, each and every course requires its own accreditation. What happened is, pursuant to the Nursing Act, regulations were passed in relation to accreditation, and it is regulation 173, in particular, and what paragraph 7 of that says is that every time you want to add additional learners to an existing institution, you are require additional accreditation. So by way of example, in KwaZulu-Natal, Netcare wanted to add additional learners to its nursing institution, and it has been engaging since 2009 with the Nursing Council to get permission to add those additional nurses, and that permission still hasn’t been forthcoming. So this is part of the regulatory challenge that hospitals like Netcare face in trying to increase and supplement the number of nurses, and there are certain regulatory inefficiencies in the existing system which unfortunately are hampering those efforts.

There are also significant restrictions on the employment of foreign nurses. Now, because of the nursing shortages in South Africa some of the hospital groups, and I don’t think Netcare is alone in this, I think Mediclinic has likewise indicated to you yesterday that they sought to see whether they could employ foreign nurses, but there is a significant bureaucratic rigmarole involved in employing foreign nurses. Now, I
don’t think for a minute that we would suggest that there shouldn’t be oversight, that there shouldn’t be regulation, that there shouldn’t be a process for ensuring that if you are bringing foreign nurses into the country that they suitably qualified and that they don’t have a poor nursing history, but unfortunately the current process, and there have been these guidelines published by the Nursing Council for registration of foreign nurses, are incredibly burdensome. You are required, by way of example, a letter of support from The Department of Health if you want to bring in foreign nurses. You require their credentials to be assessed by the South African Credentials Association. There are a range of other requirements, regulatory requirements, including writing exams in South Africa even if you are a highly qualified nurse in other countries, and all of these things effectively impair the ability to bring in additional nursing capacity into the country.

Again, Chair, we think that the Department of Health has recognised these issues and I don’t think that there is a great deal of difference of view between the private sector actors and the Department on this issue, but there needs to be greater capacity building initiatives, and I guess the question really for the panel to consider is, are there ways of streamlining or making the current bureaucratic process more efficient? We are not suggesting that there shouldn’t be one, but the current process really impairs and impedes the ability of hospital groups to bring in additional nursing and capacity.
Chair, I want to then move on to surgical’s, medical devices and medicines. As you have heard from Ms da Costa’s presentation, surgical’s, medical devices account for a significant proportion of medical scheme spend at Netcare, somewhere between 25 to 30%. Medicines are charged at the single exit price in terms of the Medicines Related Substances Act, so there is no mark up, it is simply charged at the single exit price, and similarly medical devices and surgical’s are charged at the cost price, net acquisition price. What Netcare did in 2010, they got a whole lot of data from their UK operations, and they compared some of the prices on medicines that their UK subsidiary was purchasing against the prices of the same medicines that they were purchasing in South Africa, to have a look at what the potential cost differentials were. Now, if you look at this slide you will see that there are significant cost differentials. I mean, in some instances up to 1,000%. Now, that may be a function of a variety of factors, but from a regulatory perspective the question that we have always asked ourselves is, is there a way of bringing down drug prices in South Africa through, for example, parallel importation? If there are equivalent drugs, the same patented drug which is much cheaper in other countries, could you simply parallel import the product into South Africa, and thereby reduce drug costs significantly in South Africa? The difficulty unfortunately, again, is a regulatory one. Section 14 of the Medicines Act says that you may not sell a drug in South African unless it has been registered, you
also may not parallel import a drug, in terms of section 15 (c) of the Medicines Act, unless the Minister has prescribed certain conditions relating to parallel importation of the drugs. Now, I think that provision was intended to be an emergency provision, you know, for particular instances where drugs were very expensive in South Africa and emergency circumstances warranted the Minister prescribing those particular conditions, but the difficulty is that the Medicines Control Council has published certain guidelines for parallel importation, and what they have suggested is that you can, in terms of section 15 (c), apply to the Minister for a permit to parallel import drugs., but, Chair, we are not certain that from a legal perspective the guidelines actually accord with the legislation, because the legislation seems to envisage the Minister actually prescribing conditions, and that doesn’t appear at this case to have been the case across the board. So that would be a regulatory inhibition to parallel importation where there are significantly cheaper drugs which could be brought into the country.

Chair, I want to touch briefly on the topic of hospital licensing because I think that has been an issue that you have raised a number of questions on in the last few days, and in fact as recently as yesterday, I think you raised a question with our colleagues at Mediclinic about the regulatory regime around hospital licensing and where do we currently stand as far as that’s concerned.
So, under the existing regulations as they are being applied by the various provincial departments, you not only require a licence to open a new hospital, but you require a licence if you want to add on to that hospital, and even if you want to convert existing beds. So by way of example, let’s say you have got a licence for 100 paediatric beds at a particular hospital, you find that you are not using all of those beds for paediatric purposes and you want to change some of those to orthopaedic beds because there is now an increased demand, you can’t do that without permission, and the same regulatory process and the same regulatory time period applies. Chair, we have provided you with a very detailed list, in annexure C to our regulatory paper, which sets out all the various instances where Netcare hospitals have applied for permission and for licences to extend beds, to change beds, etc. and we have given you indications of the extensive time periods that are sometimes associated with that., sometimes a year to two years, sometimes three years with no response, sometimes no feedback at all. In other instances you get a response which simply says from the particular government department, you can convert eight beds, but not the full 20 beds that you have applied for, no reasons are given.

In other instances for new hospital builds, lengthy periods in some cases, a year to two years with no response and then all of a sudden the response is your application is declined, for no apparent reason. Chair, I don’t think it is controversial to say and the
Department of Health I think has quite fairly acknowledged, that there is a fragmented approach to hospital licensing in this country. Each provincial department, some apply the same regulations, some don’t and their application of those regulations is quite different.

Chair, you posed, I think, the crucial question in the last few days which goes to two issues. The first question you posed is, are the existing regulations that the Provincial Health Departments are applying, are they still properly in force? I think the question that you posed is because of the repeal of certain provisions of the 1977 Health Act which came fully in to force in 2012, what does that mean for the existing regulations that the current departments are applying, and have those regulations effectively fallen away as a consequence of the repeal of the previous Health Act in 2012? Chair, we have got a provisional answer which I think may assist you, I am not going to suggest that it is a complete answer, but I think you posed this question to Mediclinic yesterday, and I would like to have a stab very briefly at trying to explain how we see it. So under the Health Act of 1977, the Minister passed various regulations, one of them, which was regulation 158, which I think the panel is fairly familiar with, and this is the regulation which the Gauteng Department, the Eastern Cape and KwaZulu-Natal apply in relation to hospital licensing. Certain provisions of the 1977 Act were assigned to the various provinces in 1994, and that included section 44 of the old
Health Act which provided for regulation of private hospitals. As a consequence of that assignment, a number of the provinces then just simply adopted those regulations 158, so Gauteng did that, the Eastern Cape and KwaZulu-Natal. The Western Cape, as you heard in your session with them did something different. They used the powers under section 44, the assigned powers, and they effectively enacted their own regulations, which is regulation 187, Chair, and they repealed the previous provisions of 158. The Free State has done something completely different. So in 2014 they have used the provincial legislation, provincial health legislation, and they have enacted their own regulations and they have repealed the previous 158. So they have now gone a different route and used the Provincial Health Act to introduce their own licensing regulations. The question then becomes, well when the provisions of the 1977 Act were totally repealed in 2012, what happened? I think, Chair, one potential answer that you may wish to consider in this regard is, the provisions of section 93 (2) of the National Health Act which effectively introduced a savings provision, and what the savings provision said was that if you had effectively done something which could be done under the new Act, that effectively could be saved by virtue of that savings provision. Now, it is a question of legal interpretation, and I am not going to suggest to you today that we have got a definitive answer on this, but potentially that savings provision may mean that the existing regulations around hospital licensing are still
lawful and are still able to be implemented. I think, Chair, one question that you did pose, which I think is definitive, is whether the health departments of the various provinces can amend the current regulatory regime, and the answer is that unless they are doing it under the Provincial Health Acts, they can’t, because the previous power to do so was repealed in 2012. So effectively where we sit today is we have numerous provinces, some of which apply the old regulation 158, the Western Cape applies its own 187, the Free State has now imposed its own regulations pursuant to the Provincial Health Act, and very recently, in fact the Free State had a moratorium on private hospital licences which was only lifted in the last two weeks. So each of the provinces is applying a different way of approaching this issue and obviously that leads to considerable inefficiencies in the current system of hospital licensing.

JUSTICE NGCOBO There is an old case that I can remember, DVB, I think it was, which may provide some answer as to whether or not they have the power to repeal legislation that was assigned. It would provide an answer, but it is a fairly old case, I think it is 1999, if I remember the case very well. It had to deal with the North West Proclamation 293, I think it is. I can’t recall the full name.

MR NORTON Chair, I don’t have an answer, offhand, but I will defer to my much more learned colleagues, Mr Unterhalter and other counsel on that point. I think,
Chair, in short, our submissions to the panel are really that something has to be done about this, because there is not a unified system throughout the country. Apart from the Western Cape, the Western Cape is the only health department whose regulations provide for time periods for processing hospital applications. None of the other health departments have specific time periods built in for processing hospital applications, and that is a function of the wording of the old regulation 158. Gauteng did try and introduce new regulations in 2015, but withdrew those draft regulations because they realised they didn’t have the power to enact amendments to the existing regulations so those have been withdrawn. So we sit in this unfortunate situation of a fragmented approach, and apart from the Western Cape no time periods for assessing applications, often no reasons given, and a failure really to observe general provisions of administrative provisions under PAJA.

Chair, in conclusion, we think there are some significant inefficiencies in the current regulatory regime, whether it is in terms of the Health Professions Council, whether it is the way in which the Nursing Council operates, whether it is in the way in which the current hospital licensing regime currently operates, which we think the panel would need to consider and take in to account.

Chair, there is one final slide from my side, and I realise that this is very early days in
this debate, and we certainly don’t want to pre-empt anything that the panel will be considering in this issue, but we did think it was worth just two minutes on this particular issue. Chair, some of the stakeholders that have appeared before you have suggested that the panel may wish to consider some form of price regulation in the private healthcare sector, whether that is in relation to hospitals, whether that is in relation to doctors or across the board. We just thought that we would maybe make some very preliminary submissions and give you some thoughts in that regard, and we have included just one indication from the UK private healthcare inquiry which obviously preceded your own by a year or so, and we think that there are a couple of issues that the panel may just wish to consider in regard to this issue. The first, Chair, and I think this was something that the UK Commission acknowledged in its inquiry, is that before one would go down this route, the panel would have to be convinced that there was a strong and comprehensive body of evidence of market abuse. In other words you would need to be satisfied that there is a comprehensive body of evidence of anti-competitive conduct, whether that be excessive pricing, other forms of exclusionary conduct, other forms of anti-competitive abusive behaviour which would warrant some form of remedy of this kind. So that would be the first point of departure. The second, Chair, is that you would need to be satisfied that there are no other remedial measures that would more than adequately cater for any anti-
competitive issues that you identified. So again by way of example going back to the UK inquiry, one of the recommendations which Netcare would be supportive of, and which is being implemented in the UK, is that they said that there should be an independent body which gathers information from hospitals and clinicians which publishes outcomes so that members of the public and schemes and everybody else could be aware of clinical outcomes, etc. That was one of the key recommendations in the UK inquiry and that is certainly something along those lines we would be broadly supportive of, Chair. So I think the second point would before the panel would just need to consider whether there are not, if you do identify any particular anti-competitive issues, are there other remedial measures or other steps which would address those. The third point, Chair, and I guess this is perhaps a point that I have alluded to already, we already have significant difficulties in certain of our regulatory oversight functions in South Africa already, and I have already alluded to certain instances, the Health Professions Council, the Nursing Council, the licensing issues, to add more regulation and additional regulatory bodies where the existing regulatory system is not functioning optimally and effectively would be something that we think the panel would need to consider very, very carefully. Lastly, Chair, and I think this is probably a bit of a point that is in a sense comes from a competition lawyer, intrinsically, but our competition bodies and the Competition Tribunal, in particular,
has suggested the price regulation should be an option of last resort in a competition context. Chair, you might just want to look at the judgement of the Competition Tribunal in the Mittal excessive pricing case, and the previous chairperson of the Competition Tribunal, David Lewis, may have made some remarks in that context.

Chair, thank you very much for your patience. I don’t have anything further to add. Chair, there is nothing further from my side. I was just going to say that Mr Unterhalter has number of short submissions that I think he would like to make, on a paper that we submitted, Chair, and I don’t know if now is an appropriate time or whether you would like to take a break?

JUSTICE NGCOBO It would have been preferable if you had also drawn attention to those countries where a regulation has been implemented, and perhaps successfully, if there are any of those countries, but I do understand that this is just your preliminary reaction.

MR NORTON Absolutely, Chair. I think there is a much more comprehensive and detailed debate that needs to happen, but we just wanted to give you an initial flavour of some of our preliminary thoughts on this topic, just because it had been raised by some of the other stakeholders, and we didn’t want it to go unsaid at this stage, Chair.
JUSTICE NGCOBO  You just wanted to flag the point.

MR NORTON  Correct.

JUSTICE NGCOBO  In your enthusiasm to flag the point you may well have put the bar probably too high, though, that it must be resorted as a last resort.

MR NORTON  Chair, I think there will obviously be differences of perspective on that, but I think perhaps we can develop our thinking on that in due course. We just wanted to give you some initial thoughts in that regard. Thank you, Chair.

JUSTICE NGCOBO  Mr Unterhalter.

ADV UNTERHALTER  We are just still waiting for the slide pack to materialise because there is a first slide I would like to show you.

JUSTICE NGCOBO  The issues that you are going to raise, though, they are foreshadowed, are they not?

ADV UNTERHALTER  No they are entirely shadowed. Perhaps I should, while we are waiting, just indicate what it is that this last section wishes to do. We have submitted to you a fairly extensive paper on the constitutional issues and the relationship between your inquiry and section 27. We are not going to engage again in
that legal treaties in any detail.

What we really wanted to do was rather to try and situate the inquiry that you are engaged upon, in relation to section 27 and how it relates to an inquiry of this kind, under the Competition Act, and we want to do it largely in a schematic way, so let me just try and get to the first slide.

I want to spend some of my time dealing with this schematic, because this, I think, captures for us how you will think about or might wish to think about where your inquiry sits within the scheme of both regulation and constitutional obligation.

So we start at the point of departure, which is section 27 and the rights of access to healthcare. Now, as we have indicated in our paper, and as is well known, that is a socio economic right which burdens the state with an obligation, in the first place, to take reasonable measures progressively to achieve access rights., and that is where the positive obligation rests, and it is to take both legislative and other measures.

Now, the measures that the state has taken are numerous, but for the purposes of your inquiry, the one that is most relevant, is the Competition Act, because this inquiry engages a market wide inquiry under the Competition Act. We would understand and do understand the Competition Act to be one such response, at least in the healthcare
environment, to the section 27 obligation, because what it is concerned with is to examine whether there are market distortions, restrictions and preventions of competition that may have an impact on access to health, but although that inquiry is vital and, for the purposes of a marketing inquiry, it is distinctive, by reason of the fact that it is a market wide investigation, rather than a conduct specific investigation, which would be what one would be looking at if one was considering specific restrictive practises, as one would, in other parts of the Act, though it would be a market wide inquiry, it is nevertheless restricted by this consideration, which is that one is concerned with the question of access as markets can deliver that access, and this is where there is potentially great scope for expanding this inquiry beyond what it can properly accommodate within the scheme of the Competition Act itself.

So I think, Chair, as you, yourself have indicated in announcing this inquiry, there is a fundamental distinction between the way in which a market may be said to work and the kinds of outcomes a market may yield up for the purposes of access, and other kinds of legislative or executive intervention which will seek to secure outcomes that are relevant for access, but are not market based outcomes.

So just to make this point, because we do think it is fundamental to the inquiry, under section 27 in the positive obligations that rest on the state, you can deploy public
resources to secure access to health, and that is largely what is captured by the public health system. You can have regulatory interventions to secure access. One such regulatory intervention is the Competition Act, and the Competition Act is concerned with making sure that markets are working properly, and in so far as they do work properly, how market based access is possible. There are, of course, other forms of intervention which may do different kinds of things. They may seek to regulate the market, as we have seen in a number of ways, and they may also seek to ensure that the kinds of outcomes that markets might yield up should, for various reasons, be changed or in some way mitigated through regulatory intervention.

The key point as far as our understanding of this is concerned, is to understand these different forms of intervention, understand how they relate to each other, but not to seek to be engaged in, as it were, an act of super regulation of all the outcomes that regulation may secure in respect of health access, but rather to understand two fundamental things. The first is that under a market inquiry under the Competition Act, one is concerned primarily to understand how the market works, where are there restrictions or distortions in that market, and must they be remedied and how can they be remedied. That is the principle focus of what you are engaged upon. We recognise, however, that there are two features of that inquiry that you will almost certainly have to take account of. The first is, one which has been very fully ventilated in the hearings...
today, and to date, which is that the market operates within a regulatory structure. So for the purposes of your inquiry you will need to think about what competition is possible and what outcomes are optimal under steady state regulatory intervention, by which I mean to say, taking the regulatory structure as it is, and considering what the market can do within that regulatory scheme, what are the kinds of outcomes that a market free of distortion can yield up. That is the one inquiry that you are engaged upon, and is probably, for all practical purposes, the principle inquiry that you are engaged upon.

If I could just move this on, you will see that what we look at in the last two blocks is recommendations to improve competition within the current regulatory environment, taking regulations as they are, what can the market yield up, are there restrictions and distortions and are there remedies that need to be applied.

The second inquiry that you may wish to engage upon is whether there should be changes to the regulatory environment, and here is the important limitation that we think is relevant to a market inquiry under the Competition Act, though not necessarily for other purposes, but under the Competition Act, what you would be concerned about if you wish to examine the regulatory environment is to understand what changes could be made to it to improve the ability of the market to yield up market outcomes. These
are some of the matters that we have engaged in relation to the availability of doctors, nurses and other regulatory changes that might make market mechanisms more effective.

Both of those are central features of a market inquiry under the Competition Act. What we do not think a market inquiry is concerned with under the Competition Act, is to consider a rather different set of questions, which is to say, should there be regulatory interventions that might change the kinds of outcomes that markets yield up? In other words, markets are capable of yielding certain kinds of goods. It is quite plain that those kinds of goods are not the only kinds of goods that matter and in distribution terms they sometimes are not goods, often in poor countries that are available to all.

Now, the distributive consequences of market based outcomes are things that sometimes and often do require intervention, partly through public health provision, but sometimes through regulatory interventions which will alter the distribution of outcomes that a market would otherwise yield up. That is a matter for the executive in parliament in other guises to determine, and in our submission, quite a …

**JUSTICE NGCOBO**  Are we entitled to make that suggestion to the executive in parliament?
ADV UNTERHALTER  Not in our submission. We said that is no part of your remit, because the remit of a market inquiry is the two boxes that come at the end here, are there distortions to the market within the existing regulatory structure, and is the existing regulatory structure inhibiting and distorting of competition? Those are the two inquiries.

The question as to whether the market is yielding outcomes that are outcomes that might need to be mitigated or ameliorated in some respects, that is the matter for other interventions, and because there have been such wide ranging submissions made to you, quite understandably because everyone is concerned about the issues that arise in this inquiry, at a certain point you will need, with respect, to give some thought to disciplining what it is that your inquiry is about, because otherwise there is a risk that you lose the impact and force of what your recommendations will be, because they become diffuse and stray into territory that, frankly, is part of another set of interventions that are made by other actors, more particularly, the executive and the legislature in other guises. So whilst it is important to be aware of the limits of markets and the limits of the kinds of outcomes that they can yield up for access, the key variable for this inquiry is to say, the market is one mechanism which yields outcomes that can promote access, it is not the only one, but it is one that can have this effect.
Your mandate is to ensure that the market is operating so as to secure the outcomes that do promote access.

One last thing to say about this is the following that all this will then lead you to the heart of the inquiry, which is to say, are there distortions, are there restrictions on competition, and then if you believe that there are, what are the remedies that are appropriate to cure those distortions.

If I could just say two things about this. We know, and these are really for the sessions to come, that there are many debates to be had over hotly contested issues concerning whether there are restrictions in competition or not. Fundamental to that issue are the following questions, which is, are, for example, pricing and the relationship between price and costs something that is part of a restriction of competition and some form of abuse of market power or does it arise for other reasons? That is one of the perennial issues that you will come back to time and time again. What is the causal explanation for some of the phenomena that you observe in the market place?

What is important, though, about the inquiry is, that’s at the heart of your considerations. Is it distortion in the market that is bringing about the phenomena that you seek, that you are concerned about, for example, around pricing and the like, and once you engage the causal inquiry, you will need then to come to certain conclusions...
on that issue, as to whether it really does flow from restrictions of competition or forms of abuse in the market, and then you will engage in the second phase of all of this, which is to say, well what are the remedies, and there are just a couple of very short things to say about that because this is the sequence, ultimately, that you will, with respect, need to go down, but the question in all market inquiries of this kind and competition inquiries of various permutations is always to consider the issue of over extensive remedies and under inclusive remedies, because the intervention that is taking place is being done for the purposes of bringing the practise into line with what you think the market should achieve. Of course, all of these interventions are then subject to this general problem about remedial conduct, which is, is it necessary one, and secondly if it is necessary, is the particular remedy effective, and is it effective in the sense that it is not going to have perverse consequences, either because it is insufficient to do the work that is required to remedy the problem, or it does too much work and so has perverse effects in respect of having unintended consequences, which itself restricts access.

So the remedial inquiry is a very important one and the only reason we raise it at what might seem to be a very early stage is this, that it is very easy in the context of thinking about remedies to take what we think is a misstep, which is to start going back into an inquiry that we think is not yours, which is to say, should we have regulatory
interventions which seek to change market outcomes in the sense of the kinds of goods that markets produce, and very often what happens in this is that when you come to the remedies portion, one then starts to engage, as it were, upon a regulatory course of action which really is not concerned with making sure the market works, but making the sure that there are measures in place that do things that markets can’t do, and that is a risk we would just like to flag, because it is so easy to fall into that expansive regulatory mode, which as it actually is not tailored to the central purpose of your inquiry, and much of that is captured with the ambiguity of what is said to be market failure.

We have highlighted this but time and time again it is worth reflecting on what that means. There are two important senses in which it is used but they are not the same. Market failure in the competition law sense of the word, under your inquiry, concerns whether there are restrictions and distortions of competition in the market and abuse of market power. That is what market failure is about. Market failure in a competition inquiry is not concerned with those things that the market can’t do or those forms of access that are perhaps socially required, but which the market can’t meet. That is a different form of market failure, and, with respect, we say that is not part of your remit.

So we make these comments and hope that it is of some assistance in seeking to situate
some of the debates that we have already had and no doubt ones that are to come.

Thank you.

JUSTICE NGCOBO I think it will be helpful when you do come back to bear in mind that the terms of reference initiates the inquiry under two situations, as provided for in the Act. The first one is the one on which your entire argument is based, and that is where there are distortions. The other one is when it seeks to enhance to achieve the purposes of the Act, which is the second one. So you will recall that the terms of reference make that point. The purposes of the Act are set out in, the primary purpose of the Act, as you will recall, is to promote competition, but promoting competition is not an end in itself. There are these objectives that are set out I think in A to F, I think it is, whatever the last [indistinct 3.06] that is. That is one of those objectives. So I think when you come back and when we interrogate these issues more fully, if you could also address that particular aspect, which is quite different as we see it, from the first one.

The second issue is in relation to the context, is also to bear in mind the provisions of section 39 of the Constitution, which requires us to, when we interpret legislation, to do so in a manner that promotes the objectives of the Bill of Rights, which include the
right of access to healthcare.

The last point that I think you should also bear in mind, when we have to deal with these issues more fully, is the fact that more recently, I think it was last year if I am not mistaken, South Africa ratified the International Convention on Economic, Social and Cultural Rights, which now means that the access to healthcare is not just a constitutional right, but it is also an international right which has been incorporated into our law.

More importantly, though, is what is the impact of international law, in particular, general comment 14 which deals with the right of access to healthcare?

I think those are the issues that you may want to consider when we have to deal with the regulatory from more deeply.

**ADV UNTERHALTER** Yes, thank you. We, of course, take all of these three points in to account. We would just make one observation for now, and we will obviously return to all of these things, which is that the submissions that we have made on this score, we would suggest actually fall within the scheme of section 2 in the purposes of the Act as well, because the listing of the matters in A to F is all predicated on the introductory language, which is concerned with the promotion and maintenance of
competition. In other words, the Act is not one which says that all of these purposes will be secured independently of the maintenance and promotion of competition. It is the maintenance and promotion of competition in the market that is the mechanism to yield these social goods, and that is why it is the market based inquiry. There are other ways of producing these goods but for the purposes of the Competition Act it is the market that matters.

JUSTICE NGCOBO Those issues that I have just raised with you, you might want to come back when we have to deal with these issues more fully.

The time now is about twenty to twelve. I wonder whether it would be convenient, are you all finished with what you wanted to say?

MR NORTON We have, Chair, thank you.

JUSTICE NGCOBO Very well. We will take a break now, we will come back at twelve o’clock and then we will seek clarity from what you have told us.
Session 2

JUSTICE NGCOBO ... assess the quality of the healthcare services that are provided by Netcare to your patient.

MS VAN DER BERGH We do that in two ways, the one way is we audit, so we have audit teams, and the second way is we evaluate the measures that we've developed [indistinct].

JUSTICE NGCOBO [indistinct] past five years, is that right?

MS VAN DER BERGH Well, what they’ve been doing for the past five years is identifying the measures, finding ways to collect them.

JUSTICE NGCOBO Well, perhaps you must explain them to me. Precisely what is it that you’ve been doing? I want to know about the assessment of the quality of the services that your patients are getting. Have you been doing that?

MS VAN DER BERGH Yes.

JUSTICE NGCOBO Is that what you’ve been doing for the past five years?

MS VAN DER BERGH Yes.
JUSTICE NGCOBO  During the last five years that information has not been made available to the public or to your patient.

MS VAN DER BERGH  [indistinct] available to the patient [indistinct] reports.

JUSTICE NGCOBO  Now, you’ve taken a decision that it would be made available.

MS VAN DER BERGH  Yes, we have.

JUSTICE NGCOBO  When was that decision taken?

MS VAN DER BERGH  It’s been taken over several years as this question of how do we make all our data [indistinct].

JUSTICE NGCOBO  But it was never implemented.

MS VAN DER BERGH  Probably implemented until [indistinct].

JUSTICE NGCOBO  I see. So what you're saying, you're saying that when this process started five years ago, the purpose of the exercise was ultimately to make this information available to the public.

MS VAN DER BERGH  Yes.
JUSTICE NGCOBO  So now you're going to make it available to the public.

MS VAN DER BERGH  Yes.

JUSTICE NGCOBO  This year or when?

MS VAN DER BERGH  [indistinct] ready to do that, Mr Chairperson.

JUSTICE NGCOBO  Okay. You’ve heard other stakeholders tell us that they had never considered this but effective, but they’ve now taken a decision to make the information and the quality of healthcare service made available to the public.

MS VAN DER BERGH  Yes.

JUSTICE NGCOBO  [indistinct] they never thought about that previously.

MS VAN DER BERGH  I have heard that.

JUSTICE NGCOBO  Yes. Now, [indistinct] in your case. In your case you’ve always wanted to publish this but you were still busy collecting the data.

MS VAN DER BERGH  Yes, and [indistinct] through the Office of Health Standards [indistinct] we knew there would be a set of data that they would want to collect and collate, so [indistinct] so they have known about it and they have had the commitment.
JUSTICE NGCOBO My colleagues will then put questions to you, starting with Dr von Gent.

DR VON GENT Yes, Ms van der Bergh, I want to follow up on this, and you knew I was going to follow up, I think.

MS VAN DER BERGH Yes.

DR VON GENT On these issues. So I understand the sequence, I understand what you said, the starting work, first of all on internal information on quality, share that with the hospitals and the doctors, and [indistinct] to improve both the system and the quality of the provided.

MS VAN DER BERGH Of the data.

DR VON GENT I understand that. In five years’ time you still, a decent time, I think, to work on that before you eventually embark on publishing and making it available to the more broader public. In your presentation you said, we are now ready to make it available to both schemes and the public and the patients. You say you have never made these available or you didn’t use this in negotiations with schemes before.

MS VAN DER BERGH We have presented our data to schemes, so for the past four
years [indistinct] annual basis or sometimes twice a year we take that data and we present it to them.

**DR VON GENT** Is that a hospital level?

**MS VAN DER BERGH** It’s available, we do it at a group level and then that is the detailed data by hospital, it is also available.

**DR VON GENT** To the scheme.

**MS VAN DER BERGH** To the schemes if they [indistinct] information, we can provide that and more recently in the last year some of the schemes have had their own data above our hospitals and we have engaged with them and we shared the data in that way.

**DR VON GENT** Of course. So if I understand correctly, for schemes, if they’re interested, they are ready for a couple of years are aware of the quality, the way you have defined it, collect it, of the individual hospitals within the Netcare environment.

**MS VAN DER BERGH** [indistinct] they have this data, they [indistinct] specific questions about it from time to time.

**DR VON GENT** Could these schemes have used this information publicly, could they
have used to convince or to inform their beneficiaries?

**MS VAN DER BERGH** The difficulty within our discussions with the schemes is the issue of comparability. So it’s been a continuous process of us talking to each other about ensuring that we reach consensus and build a system that will enable [indistinct] data to be made available to the public and that’s one of the reasons we've been working very hard, both with the Office of Health Standards Compliance on the concept of how do we make sure that the responsible [indistinct] the information we will provide to the public.

**DR VON GENT** I fully understand it. That’s a major issue, how do you make this comparable. I’ll come back to that one. In principle, because hospital groups have made us aware, the fact that, particularly the larger schemes are at an advantage in the sense they know better, actually, how to compare the different performance indicators of the hospital groups across the country than the individual hospital group does, it’s an advantage or has been presented as an advantage in the negotiations. So they could eventually have been collecting this data from you and compare individual hospital across hospital groups and could have, could they in principle have used that information to inform that to their beneficiaries, or would you stop them from doing
that?

**MS VAN DER BERGH** I don't think that [indistinct] is request that they cautiously do that, you know, [indistinct] asked them actually probably [indistinct] to do that without the consensus in that process, so, yes.

**DR VON GENT** So it’s not, and we’re very happy, I could feel your passion on quality from seven metres apart, on collecting quality information, I think you’re on the right track, if I listen well. The next step, of course, is make this information available to the public at a hospital basis, and the huge next step is to make it comparable across South Africa.

**MS VAN DER BERGH** Agreed.

**DR VON GENT** And that is a huge step because if I, so we have the privilege of [indistinct] a third party every year on the big hospital groups and of course NHN and you see everybody works on its own but does not cooperate or agree on standards, so what to measure precisely, which methodology to use, etc. and maybe that’s also a question to Ms da Gama, do you consider it a responsibility for Netcare to make quality information available to the general public in South Africa on a comparable basis so that they compare, so that the patient or the beneficiary could compare individual
hospitals across the country, do you consider yourself to be responsible for that as well?

**MS VAN DER BERGH** I think we’re responsible for giving the public our assurance about quality and that assurance needs to come with data. So simply saying, so one thing is we need to give the public that assurance and the responsibility for providing our contribution to a process for the public to have more information about the whole market, I think we would have a responsibility to put that forward.

**DR VON GENT** How does that responsibility translate in practise, how is that being translated in practise?

**MS VAN DER BERGH** Well I think our commitment to working to the Office of Health Standards Compliance is part of that contribution and they have both the responsibility to contribute to the methodology and to the way in which you're doing it and once that’s been promulgated and once we have that in place, to actually then cooperate and provide our data into that system.

**DR VON GENT** But the healthcare standards compliance doesn't tell a patient that has a bad knee or a hip or whatever not very much what doctor and what hospital to choose in that particular instance. So, Ms da Costa, yes.
MS DA COSTA  Thank you, Dr von Gent. If I can just step in here. So there’ve been various process of us trying to understand how it is that we could get the industry to publish information in such a fashion that it is consistent, collated by independent parties and then 2011, we actually, through the Hospital Association, contacted the Competition Commission and asked them how they would feel with us publishing through the Health Systems Trust some basic data on healthcare in South Africa, be it numbers of beds, nurses and a few metrics. At the time we got a pretty neutral response back that was interpreted by some as potentially non committal and in expectation of this inquiry and being thoroughly concerned about previous experience, about collective engagement on topics, we decided to see this process through to a completion. We are completely amenable, as Netcare, to a collective process of publishing data. The issue that you raise is absolutely appropriate, how do competitors get together and find agreement. Right now we have differences of opinion with respect to some of the numerators and denominators, but we think, be it through the process that Dena’s speaking of, that’s been a quite a bit of a long process but it has been to flesh out and arrive at these definitions, be it the Office of Health Standards Compliance or be it any other process, and what I want to share with you is through the, one of the remedies that came out of the Healthcare Market Inquiry in the United
Kingdom led to the creation of a private hospital information network which basically required the publication of certain quality data.

**DR VON GENT** I know. That’s true, and there's a number of initiatives around the world where parties got together and collaborated on standardisation of quality metrics in order to make competition possible on quality. I mean, it’s a precompetitive effort, it’s not an anticompetitive effort. I would be happy to see any decent competition authority that would [indistinct] that type of cooperation. My question is, is there a commitment of Netcare to contribute to the viability of competition in this context? We have challenges in South Africa, one of the challenges is information that is obvious, I think we’ll find hard empirical evidence on that during our inquiry, but it can be easily, I think, agreed amongst ourselves that the information is a problem. Do we have a commitment from you to contribute, and what we see, what I saw over the last couple of days is parties pointing to government or to other parties that should take action, but not too much taking action themselves, so ...

**MS DA COSTA** Thank you, Dr von Gent. I can certainly respond to that, and it’s an unequivocal yes, and just to give Dena a little bit of credit, because she undersells herself, but through the Best Care Always programme there have been a lot of initiatives to bring parties together and engage on this. There actually have been, over
the last two years, quality improvement summits that really brings the parties together and sets a focus on these specific topics. So not only will we participate, I think that Dena’s been playing a significant leadership role to this effect.

**DR VON GENT** Can we have, before our inquiry ends, that’s before the end of the year, have your position on this, what actually you would take or have been taking after this inquiry, thank you very much. I've got two topics. Yes, follow up.

**JUSTICE NGCOBO** I think you must understand, ma’am, why we ask, why we’re interested in this. When patients get sick, they don't have information about a doctor to go to, invariable, the quality of the services that they would like to go to, and they get referred to a hospital. They’ve never been to that hospital, a specialist, perhaps, refers them to the that hospital. There’s no way of knowing how good or how bad that hospital is, and the kind of treatment that they are going to get at that particular facility. That’s the information that is critical to a patient for that patient to be able to make an informed decision, that’s the context in which we are probing this EC. Do you understand that?

**MS DA COSTA** Thank you, Chair. We fully understand that.

**JUSTICE NGCOBO** Yes. You know, what the other groups have been candid about
is that it is an issue that we have never considered, others have told us that one of the
problems that we’ve had in the past is how do you collect and assess the data, because
until such time that there’s some agreement on those issues, it’s difficult to give that
commitment, and that’s understandable.

5  **MS VAN DER BERGH**  I think I understand you fully and I think, you know, I just
want to reiterate that we fully support that and we’re more than willing to engage and
to continue this whole process and with speed and urgency, actually. So, yes, I don't
know if there’s any more questions, but thank you.

10  **DR VON GENT**  I've got two topics I want to touch on briefly before I give the floor to
my colleagues. Ms da Costa, in the past you made two remarks that sort of flagged,
one was very brief. You said in UK we are able to employ doctors, isn't it, is that true,
are you sure you’re able to employ doctors in your private, your commercial practice?

15  **MS DA COSTA**  So the context of the comment was specific to those NHS projects,
but I can confirm that there is no restriction on employment of doctors in the United
Kingdom.

20  **DR VON GENT**  For the rest there is the same restriction.

25  **MS DA COSTA**  No, there’s no restriction.
DR VON GENT  You can employ doctors.

MS DA COSTA  You can, doctors in general choose not to and to put it into context there is, I guess, a plethora of doctors in the United Kingdom, for example, I think Discovery speaks of the fact that about 3,800 doctors do the bulk of the patients, in South Africa these are specialist. Booper, for example, whom we contract with has 20,000 specialists on their book, so there’s no restriction on the employment but it’s not a general practise within our facilities.

DR VON GENT  A matter also mentioned in the past is that you said, you mentioned to us the number of comparatives in the catchment areas as calculated by [indistinct] 0.17.26 and I’ll go into that, we’ll come back to that at a later stage of the inquiry, obviously. Why did you mention a number of competitors at the local level?

MS DA COSTA  We were actually just trying to put as much content into the presentation, we took some guidance in the prehearings and we were guided to just giving a broader overview on the context and on letting the detail go down to the sessions with the experts, so I don't think there was any absolute reason for it.

DR VON GENT  Because I was, and Mr Bishop, of course, told us that negotiations take place at a national level primarily, also at DSP level, so I was wondering why you
have us that information at the local level.

**MS DA COSTA** No, I think as we were discussing shareholding and we were discussing, it was just an overview point, nothing further to read into that.

**DR VON GENT** We’ll come back to that.

**MS DA COSTA** Thank you.

**MR CHILDS** Yes, that's correct.

**DR VON GENT** Are actuaries the people that can, am I referring to the slides that you showed us adverse selection and the effects of this at those selections on the price level around the expenditure level, actually, and the premiums of the contributions of schemes. Are actuaries the people that make a call on that? Are they the best situated to make a judgement on what the effects are of the fact that we don't have mandatory membership here?
MR CHILDS Yes, Dr von Gent. I think we are.

DR VON GENT Yes, I do think you are as well. Your assessment is quite an assessment, isn't it? I mean, what you said to us is that should we have mandatory membership in South Africa and you showed us the graph and how adverse selection affects the risk pool of schemes, then consequently the contribution that every South African that is insured pays, is significant. I mean, the effect of not having mandatory membership, if I recall well, what would you say, how much would premiums go down if we would have a mandatory membership tomorrow?

MR CHILDS Dr von Gent, it would depend obviously on the individual scheme’s circumstance and demographics and what members came into each particular scheme. Especially it would be different between restricted schemes that currently aren’t exposed to that selection and open schemes. For the market as a whole my estimate is that premiums at a meta level and at a macro level could come down in the order of 15%.

DR VON GENT Premiums would go down in the order of 15%. So we have first real significant cut back on costs.

MR CHILDS Correct.
**DR VON GENT** For the South African population, just through that one measure. You work for Netcare, obviously, that side of the table.

**MR CHILDS** We consult to Netcare.

**DR VON GENT** Do you work for more parties in South Africa? Are you in any way compromised in telling us that 15% will be the, can you tell us ...?

**MR CHILDS** Dr von Gent, by virtue of being a consulting firm, we conduct consulting activities widely across the market, healthcare and other markets. In this particular case we were hired by Netcare. I think the evidence in our report stands on its own two feet and I don't believe that we’re conflicted in any way.

**DR VON GENT** You work for schemes as well.

**MR CHILDS** Yes.

**DR VON GENT** You work for the government sometimes.

**MR CHILDS** Sometimes.

**DR VON GENT** So you have no interest in giving us a story that is biased in any way.

**MR CHILDS** No, no direct interest, no.
DR VON GENT  Is this conclusion highly contested amongst your colleagues?

MR CHILDS  I wouldn’t presume to speak for them but I’d be so bold as to say, no, I don't think so.

DR VON GENT  You don't think they’ll contest it.

MR CHILDS  No.

DR VON GENT  We have heard qualifications of this type of research as being anecdotal. Can you give me your professional response to that?

MR CHILDS  Sure. There’s always the risk that analysis is anecdotal when you look only at a subset of the market. What I try to do in this piece of research is gather as much data as I could on as much of the industry as possible. I think the strongest findings, even though they appear to be at a very high level come from aggregate industry data, using the complete statutory returns from medical schemes obtained from the Council of Medical Schemes, so this is the age profile and demographic profile of the whole medical scheme industry, and looking at the long term trends of restricted and open scheme medical contributions. For me, those two corroborating pieces of evidence that not only point in the same direction but are very similar in order
of magnitude, given the effect that we’re trying to isolate. I mean, that I don't think in my professional opinion the evidence is anecdotal.

**DR VON GENT**  This is not anecdotal, this is systemic.

**MR CHILDS**  Yes.

DR VON GENT  Thank you very much. I'm done, Chair.

**DR NKONKI**  Thank you all for your very interesting presentation. My first question I think maybe is directed to Mr Mark Bishop. First, I’d like to know if, in your negotiation processes you do encounter administrators negotiating on behalf of several medical schemes.

**MR BISHOP**  Thank you, Dr Nkonki. Yes. Quite often these schemes, I know administrator, the negotiations would be led by the administrator with mandates from those schemes.

**DR NKONKI**  Does this concern you?

**MR BISHOP**  We've never had difficulty with this. It enables a process. I think from a perspective of competition law, I wouldn’t be the right person to ask whether there is a level of concern, but we've been able to engage over the period of time without
problem.

**DR NKONKI** So do you consider this appropriate behaviour?

**MR BISHOP** I certainly don't believe that it’s appropriate, and as I say, I'm not in a place to judge whether it really is. I think it comes down to what it is that they are discussing behind the scenes and what those terms are, but inappropriate, possibly not.

**DR NKONKI** In your experience do they tend to negotiate a similar rate for their schemes or not?

**MR BISHOP** The schemes will have different rates across them but that does depend on what is generally the same, would end up being the percentage increase on an annual basis, that is negotiated, and that could quite often be common. There might be differences based on networks that individual schemes administered by that administrator have, and there could be differences in those annual increases on that basis, but the premise of the negotiation would be individual, would be looking at one number, originally. I suppose the danger comes in is where there might be a negotiation which shows a collaboration of open with closed or with more than one open scheme, that would certainly be wrong.
DR NKONKI  Is there anybody else who would like to comment on the appropriateness of that behaviour, on your team, or not?

MR NORTON  I think it’s a difficult question from a competition law perspective, and I think it’s not one that has been determined by the competition authorities as yet, and I guess there probably are different perspectives on that issue. I think there certainly is a school of thought which might suggest that some of that might be regarded as collusive but I think it’s a difficult ultimate call to make.

ADV UNTERHALTER  The fundamental question is going to be whether the schemes are competitors for the purposes of the negotiation and whether deploying the joint administrator with a single mandate or at least being in a position to understand both mandates might give rise to some collusion which could give rise to some power, minopsony power. There have been some analogous situations in which the competition authorities have been concerned about these sorts of cooperations and they’ve been condemned, but the question from a strict competition perspective would be whether they’re competitors and whether this is a form of price collusion, or whether this would fall under other provision of the Act where you would have to consider it more from an effects perspective, and therefore consider whether in the overall scheme of the bargaining relationship this was a deployment of power that
would have adverse effects rather than having certain benefits for the purposes of either
facilitating the negotiations or as a counter weight to any hospital power in the
bargaining situation, but I think its effects are anomalous, if it’s an effects based
analysis, but the competition authorities may well say, you don't even get into the
effects question because if it is any, if there’s any manner of collusion involved, that
would be condemned on its face.

DR NKONKI  Thank you.  Do you want to add?

MR BISHOP   Please, Dr Nkonki.  I suppose the one add would be that this has never
stopped us engaging with funds directly.  So there’s not a shut out and if agreement
would not possibly be reached we would always reach out to schemes on those sorts of
basis, but I'm not aware of where open schemes have negotiated together.

DR NKONKI  Thank you.  My second question is with regards to barriers to entry in
the hospital market.  So you talked briefly about the licensing requirements and even in
your written submission you highlight that the process can be sometimes protracted
and it can be improved. Then you provided us with a list of new entries and indicating
that there is relatively entry into the market.  We've had the provincial departments of
health present in this week, in particular in KwaZulu-Natal, we learned that there have
been licences that have been granted and then hospitals have not been developed yet. I just wanted to know what your comment is in that with regards to barriers to entry.

**MR NORTON** Thank you, Dr Nkonki. It’s a very good question that you pose. I think our overall submission is that there are obviously severe regulatory inefficiencies in the way in which the hospital licensing process is conducted for the reasons we explained earlier, but notwithstanding that, there has still been a number of new licences that have been granted and a number of new entrants that have entered the various markets. So I think overall, and we've done quite a detailed paper by Ms Guerin-Calvert on geographic markets and on new entry. I think overall we would say that certainly while licensing is a barrier to entry, because obviously without that you can't get a licence and can't come and operate, factually, over the last few years there have been a number of new entrants and we've sought to detail that in our various papers, and I think there has also been a bit of an inconsistent application of the licensing process. So in some instances, new entrants appear to have found it slightly easier to get licences, whereas some of the established players I think may have battled more to get new licences and also to get extensions of their licences. So there’s been a bit of an inconsistent application of the licensing process, but I guess overall it hasn’t precluded new entry and there certainly has been evidence of new entry, which we've sought to detail in our papers.
DR Nkonki  Okay, thank you. My next question relates to equipment, the use of equipment in your facilities. You, in one of your slides, listed several technology advances that you, technologies that you’ve purchased that have improved outcomes. So firstly I’d like to know what process do you engage in for deciding on which equipment or technology to purchase.

MR Bishop  Thank you, Dr Nkonki. Quite often equipment might be brought forward by doctors who've seen this overseas and they’ve seen models. We would perform a health technology assessment, we have a team that purchases capital equipment and we review that. We tend to use the international reviews of that data. We would look at things such as has it been FDA approved, does it have the requisite specifications in Europe, what are the outcomes, what are the papers, the evidence based on that, and we bring that in. I’d point out that equipment is largely purchased for the matter of outcomes, does it improve, does it improve the prior technology, is it a better way to do the procedure and it is not really about revenue. One of the realities is that we would struggle to get many of those pieces of equipment chargeable, would be the right term for it, and to recover the cost of that. The big example, I think, on our list is the robotic assisted surgery. We brought that in, we've created a tariff model which means that we bill at the prior level of type of surgery, it’s not a greater cost to the scheme and to the member, and we've done that on the basis of trying to bring in
what is best evidence medicine, from that perspective. Here you have a gold standard for that use of that piece of equipment, and much of the other equipment would be done the same way. Next would be to point out that schemes are very good at they’ve got technology assessments, so they would assess whether they’re going to be paying for that piece of equipment, and that would be part of our engagement to understand as well, whether there’d been acceptance of the new modality of treatment, where it changes, specifically.

**DR NKONKI** Thank you. So of course because you’ve invested in that health technology assessment, unit that you have in house, as you know, we don't have a central body that’s responsible for that in South Africa. As Netcare, are you opposed to or are you in support of having a central body and would you be in a position to make what I would call your intellectual property in terms of the health technology assessment studies and all of that available?

**MR BISHOP** We would certainly be willing to assist with our teams who have a level of expertise, and I think you’ve heard Discovery mention, there’s Medscheme themselves have teams, but I would point out that we’d be better off piggy-backing on what’s available in the world, as trying to duplicate it. A country that is recourse constrained, specifically with expertise, specifically with health professionals, I don't
know whether it would be logical for us, with our size, to consider and institution that would be able to evaluate everything, where we could rather look at, would be the nice from in Europe, which looks at specifically this, looking at FDA rules, I think there are easier ways to do this than rather investing a huge amount of cost, based on our resources.

**DR NKONKI** When you say easier way, you’re referring to ...?

**MR BISHOP** I'm saying we could piggy-back on what the rest of the world has done, let’s use that as the measure. It’s a known fact that Medicines Control Council struggles to register drugs, but that’s because we’re doing each one individually. Now there might be times when that is right and is measured, and as you know that they're changing that entire structure right now to address some of that, but there is the ability to rather look overseas and try and gain from that. I don't know whether we necessarily need to duplicate, but whether we can use that information would be a better way to do so.

**DR NKONKI** Thanks. My last question that’s related to equipment is that it has been raised by several stakeholders that hospitals compete for specialists and they use equipment to attract. So given that you have a relationship where you’ve purchased the
equipment and the specialists are using the equipment, how do you manage that process?

**MR BISHOP** We certainly do, as an interest, obviously, when doctors are seeking that, and I would go to the example of the robotic assisted surgery. It’s not something that’s every going to recover its cost, it simply can't, so it’s about what is gold standard and good for a patient in that perspective, and, yes, you’re hoping that doctors will then work at that facility, but you're not recovering your cost. So it’s not a primary driver. Making certain that the right equipment is there for patients, based on demand, yes, and that would be our focus. I don't know if any of my colleagues wish to add.

**MS DA COSTA** Thanks, Dr Nkonki. Maybe I can just add to that. In general what I think we’re saying is that in order to ensure that the doctors want to practise out of a Netcare facility, we just want to make sure that the infrastructure of the facility is of high calibre, that we do have the technology they require, in the time of need that there is theatre space, that there is high quality nursing. I don't think that there are any structural shifts that are occurring in the market as a result of individual pieces of equipment being purchased, I don't think that you're seeing significant flows of doctors in and out of various hospital groups as a function of medical technology, per se, but it
is one of the pillars of the value proposition that we offer.

**DR Nkonki** I think my last question is a minor one on the results you presented on comparing the costs between the public hospitals and private hospitals, starting, I think, on page 37, I just wanted to know if you controlled for differences in age and different burden of disease between the public sector and the private sector.

**Ms Da Costa** Firstly we didn’t do that study, it was done at the time by, you got the source at the bottom of the slide, but I can confirm burden case mix was not taken into account and there was no demographic assessment. So there was no adjustment for aging.

**Mr Childs** Doctor, if I may just add, one of the main findings in that study was actually a comment on the lack of comparable data. So if you read the paper, there’s almost a plea to say we’d love to do this kind of analysis in some more detail, but the data’s not available, and if it were available, it would give clearer answers, but those kinds of things are the kinds of data that we’re talking about, burden of disease, demographics, etc.

**Dr Nkonki** Thank you.
PROF FONN  Thanks very much. My questions range from context to some of the other issues that come up. You put on record your investment in Lesotho. It reminded me of a paper that I recently read in the Lancet in November in which they spoke about this hospital, and I'm going to quote bits and pieces but obviously the articles in the public domain. Built at a cost of 100 million and operated under an eighteen year contract between yourselves, a consortium assembled by yourselves and the Ministry, and comments from people who are working there, and it’s a wonderful place to work. What attracted me is the quality of the facility, professionalism of the management, and because of it there is now a chance for young physicians from Lesotho to make a career for themselves at home, and then goes on to talk about the hospital that it replaced and the problems in the rest of the sector, for example, drug stock outs, and then Ministry of Health saying there are many gaps in the public health fabric, and this person says, can be directly traced to the payments from the Ministry of Health to the consortium, assembled by Netcare in several Lesotho owned businesses and provider associations that won the contract in a process stewarded by the World Bank’s international financial corporation. The cost of the new hospital is depriving the entire health system, it’s a big political mess, is the quote. Then someone who heads the private public partnership aspect of the government in Lesotho says that payments to Netcare’s consortium have increased almost eighty percent since 2008, when it was first
contracted. The rate of payment increases is scary. They then go on to say that under the terms of the contract, Lesotho’s public, which Lesotho’s public only recently apparently been made public, the consortium was to be paid 32.6 million indexed linked annual unitary charge for up to a maximum of 20,000 patient admissions and 310,000 outpatient attendances, which is about a third, they say, of Lesotho’s total hospital demand. Beyond this cap the consortium can bill extra for each additional patient. As for the initial construction funds, the government of Lesotho contributed 40% and almost 60% was provided by the Development Bank of South Africa, and less than 4% provided by Netcare. None of this should have been a secret, is the point they're trying to make, that this contract should have been public. It should have been made publish to the population of Lesotho at the time. The World Bank and the IFC, which is the agency of the World Bank, part of the World Bank Group said, nonetheless, that opening this particular initiative opened a new era for the public sector, improved these kinds of models can improve care without really adding to public expenditure, that was the World Bank’s view at that time. They then go on to say that the hospital contract granted Netcare and its consortium partners substantial profits while creating a dangerous diversion of scarce public funds from primary healthcare services in rural areas where three quarters of the population live. They then go on to say ...
JUSTICE NGCOBO  Sorry, I think if she’ll be expected to respond, perhaps to all of that, or ...  

PROF FONN  I suppose I'm going to just make one question at the end, one point.  

JUSTICE NGCOBO  Because I do think that perhaps in fairness to her, it may be necessary for her to respond to each of those statements.  

PROF FONN  Do you want me to stop after each one?  

JUSTICE NGCOBO  How would you want that to happen, ma’am?  Do you want to respond to each one, because there’s quite a number of statements that are made here.  

MS DA COSTA  Chair, I'm happy to hear the end of the questioning, I think that’s fine, Professor Fonn, you’re free to go on.  

PROF FONN  The point that they’re making is that the contract dramatically exacerbated the inequitable trend by absorbing over half of the Ministry of Health’s budget in 2013/14, up from 28% of what they paid for, for the old hospital.  The point that they go on to make is that the government of Lesotho lack the technical capability to negotiate the contract, and ended up agreeing to terms that were significantly disadvantageous to it.  The project financial forecast they decided, and I think this was after, in addition the World Bank reviewing its own data, suffered from the projection
error, resulting in a dramatic underestimation of government costs, and that private public partnerships of this kind are risky and costly and failed to advance universal and equitable health coverage. The real cost of the newly privately run hospital is already two and a half times the amount that was agreed to as affordable between the government of Lesotho and the World Bank when the contract was first awarded. I think they also go on to make the point that looking at costs alone is not appropriate, and one also has to look at quality, and I don't think anyone disagrees that the quality for the people who can access it do. The point is that what they then went back to the World Bank, who clearly advised the government on this to ask them again to review what they thought about it, and they said that the Lesotho project has proven instructive, and that effects to develop local public private partnership and require contract management, and that that’s really crucial. The project has also revealed that it’s necessary to engage in broad primary healthcare system strengthening and delivery, rather than having a tertiary centre as an island of excellence. That was one of the other things. The conclusion is that projects involving blended finance, including public private partnerships should share risks and reward fairly, including clear accountability mechanisms and meet social and environmental standards. In the right context this is the World Bank, they note the public private partnerships in developing countries are part of the toolkit but we recognise that they don't always work and that
we have to be careful about assessing each project on its own merits. I bring this up in relation to two things, one you brought this up in the context of Netcare’s involvement in the region, which wasn’t really the subject of our inquiry, so I thought a broader context was useful for all of us, and it also spoke to the notion of contracting ability, and whether you think that that’s something that you should be taking into account in developing these kind of projects, and what you’ve learned, given this broader assessment of your experiences, and the multiple public private partnerships that you’re engaged in.

**MS DA COSTA** Thank you. I appreciate the questions. So the one thing we have learned, Chair, on private public partnerships is that it is not for the fainthearted. You’ll always have antagonists, you’ll always have different perspectives. What we can share with you is that a tender was put out that was already equivalent to thirty-seven and a half percent of the budget. We’ve honoured the tender, as it was scoped. We’ve had significant interaction from the various parties, and it goes without saying that there’s some reports that will shed a negative light, there’s some reports that will shed a positive light, but I think what you should take away from this, if nothing else, is that if there is the political will and if there are learnings from existing processes that have been put in place, that the parties that do benefit is the consumer, at the end of the day, the patient. So that was the key message. The key message was the art of the
possible. I don't think is anyone is denying that the consumers have been benefited from. I haven’t seen the reports that you are referencing, and would be very happy to engage further with the relevant experts, if you would like to know more about the project.

5 PROF FONN Thanks.

ADV UNTERHALTER Can I just make three short observations? The one is the notion that Lesotho government would have entered into a disadvantageous contract at the instance of Netcare would need to be carefully thought through in the light of the World Bank’s key role in this project. The OAFC has enormous skills and capabilities, and was clearly a fundamental partner in the project, and it’s unlikely that a development agency of that kind would permit of or allow for a contract to go forward that reflected some unequal outcome. That’s the first point, and I think one would therefore need to think carefully about what some of this commentary that you’ve referenced is based on in relation to the contracting that took place. The second is there are comments that are made about how much of the budget this takes up and where the impact is felt in the assessment of where one offers tertiary or primary facilities. These are also prerogatives of the government of Lesotho. Now, I mean, clearly there are difficult choices that are made around these things and there are gains
and losses around that, but it does seem that these are choices, to some degree, that are made. Now, one can assess after the event whether they were the right choice and whether the balance was correctly struck, but it doesn't seem entirely right to assess this project simply with hindsight and not consider it from an ex ante point of view as to what was sought to be achieved and whether it did strike a policy balance that is reasonable and acceptable, though you may not agree with it in its outcome. So I do think one needs to be careful. The last point is about risk and reward, and again, one could go into this and I'm sure Netcare will if it be necessary, but again, given the supervisory role that the IFC plays in these sorts of relationships, again, it’s hard to see how the risk reward ratio would have gone so wildly out of whack under their supervisory powers.

**PROF FONN** I don't think it’s the first time the World Bank has given bad advice. I think that’s pretty much on record.

**JUSTICE NGCOBO** Were you aware of this article, ma’am?

**MS DA COSTA** No, Chair, I wasn’t.

**JUSTICE NGCOBO** I think the important point that’s being raised here is not so much these other commentary, which Mr Unterhalter seems to focus on, the question is
what does one learn from what you’ve emphasised. I understand you to emphasise previously the relationship between private and public institution in the cooperation, in the course of delivery of healthcare services. The National Health Act also, in section 45, emphasis that, and the real question is, how does one manage this relationship, and perhaps if you could share with us, if you are able to do so, what has been, what was your experience of this? The other question that I wanted you to deal with, you don't have to deal with it now but perhaps you can deal with it in a different context, and that is, I understood you to say that at this hospital you also employ doctors. Now, what I wanted to find out from you is, what is your experience of that kind of relationship that you have I think the doctors? What can you share with us, because one of the issues that you are raising with us is that hospitals must be allowed to employ doctors. You have experience of this in Lesotho. How is that working out?

**MS DA COSTA** Thank you, Chair. I think in terms of the key messages we were trying to impart with this project, it was about the flexible regulatory environment that allows for integrated healthcare. So all that Lesotho is, in effect, is a quasi HMO, it includes the integration of primary care, secondary, and tertiary care, and we were trying to share with you the value of the removal of the fragmentation of care through the health system, and obviously in South Africa everyone, it’s pretty fragmented, we don't have that continuity of care the way you would in the examples that I shared with
you, be it the Kaiser, be it, most public health systems would be hopefully less fragmented, in Brazil, I gave you two examples. So it was about the integration of care and about some of the points in the pathway that could add value, be it national procurement on drugs, be it the employment of doctors. The value of employment of doctors, one from a clinical perspective is that without a contractual nexus such as that of employment, the hospital is never fully in charge of the clinical outcomes. The truth is the doctor does make the decision, irrespective of whether the doctor is employed or not, but right now, you know, you could even try and set up a service level agreement with the doctor, but there’s no consequence to that doctor, if, for example, you’re not happy, if he hasn’t or she hasn’t shot the lights out in terms of their clinical scorecard. In Lesotho there’s a clinical scorecard per speciality, whether it’s maternal mortality rates, whether it’s readmission rates and surgical, whether it’s surgical site infections, but the benefits are multiple. One, it’s a fixed salary like I earn, as opposed to multiple salaries, depending on all the patients that you see. The Lesotho contract was a fixed budget based on a fixed set of patients. If the number of patients increased beyond that, there was an additional fee, the additional fee, for the record, is R1,500, the doctor gets paid the same salary irrespective. When you employ a doctor, he’s got to do what we do when we get to work, we've got to clock in, the doctor now clocks in. So you don't have the luxury of working for five hours and then moving on and working in the
private sector or in one other, you know, whatever the other facility is, you’ve got to put in your hours. So there are a lot of benefits that come out of it. The other is theatre slates. What we found in employing doctors in one of the NHS trusts in Manchester, we managed the collocation elective surgery unit, and there we also employed doctors. That little unit was built, it added 6% of the beds to the broader Trafford Hospital in the NHS, but it had a 23% improvement in theatre slates, just by it being able to schedule theatre better. So there are quite a few signs of efficiencies, but the single most important one is the continuity of care for the patients. I hope that answers the question.

Justice Ngcobo  How long has this hospital been in operation for?

Ms Da Costa  Chair, it was open in October 2011.

Justice Ngcobo  Are there any other private hospitals there?

Ms Da Costa  There are private facilities in Lesotho, not that I have any knowledge of their operations.

Justice Ngcobo  I understand.

Prof Fonn  I wanted to ask you, following on Dr Nkonki’s question around equipment. What we’ve been trying to understand is in relation to big items that are
usually located in hospitals, particularly radiography related, who owns them, how are they purchased, what’s the nature of the relationship with the radiography groups and radiologists around those services in your Netcare hospitals?

**MR BISHOP** In all the hospitals where there’s a radiology practice, the radiology practice is owned by the doctors. That would be a practice of one or many doctors, all the equipment would be owned by those doctors, they are tenants in our buildings providing services to the treating physicians and to ourselves, but it’s all owned for the reimbursement of those doctors.

**PROF FONN** So in some of the submissions we've been told that in fact because of the cost of the original capital investment, that it’s bought by the hospital and then the doctor, as a loan to the doctors. Does that operate in any of your hospitals?

**MR BISHOP** Certainly not that I'm aware of and certainly not in our hospitals, no.

**PROF FONN** I wanted to ask around this anti selection, I mean, we’re different to a lot of other places, but are there other countries which similarly don't have mandatory membership and do we have those same trends in those environments around this anti selection at that particular age?
MR CHILDS  Professor Fonn, I cast my mind back now to the international expert panel that came to review the intended risk utilisation framework, amongst some of the other regulatory plans, and if I recall correctly, the conclusions of that panel were that we were highly unusual in having the social solidarity pillars in the insurance framework, but not the other counter balancing regulations of mandatory membership in some form of the risk adjustment.

PROF FONN  You can't compare to anywhere else.

MR CHILDS  No, I'm saying, yes, at the time, and I think it still stands, the conclusions that we were very unusual in having such an unbalanced system, with regards to whether there is a similar dip in membership, we haven’t done such a study, it would be interesting to look.

PROF FONN  It is a question of anti selection or simply the very high youth unemployment, and so, you know, what are they supposed to pay, how are they supposed to join, assuming there wasn’t anti selection, but I'm just curious if we knew at all.

MR CHILDS  Yes, well, I mean, that’s, in the one graph, if you recall, that’s why I showed not only against the population but also above those earning above the tax
threshold and the same pattern emerges.

**PROF FONN** And then I'm not sure that any of us know the answer to this question, but I am curious around the drivers of hospital care and clearly what we’re all trying to understand is what pushes the demand, and we know that sometimes it’s me, as a consumer, I want X, Y, Z and sometimes it’s supplier induced demand and a mix of all those things and it’s difficult to understand. My question relates to if we take, for example, the massive expenditure around neonates and we also take, for example, the incredibly high costs for obstetricians around insurance, around a similar issue, part of the problem is that technology has advanced to the point where we are now saving 500g babies, whereas certainly we never did before, we would probably have a cut off at about 1,500g, and that in many countries one has to make these really difficult decisions about whether we, what sort of investments we should or shouldn’t be making and clearly within the medical profession, one of the things you try to do is to use some evidence base to drive these decisions, and the cost benefit analysis among 500 gramers is really debatable, that this is necessarily a good investment. What is Netcare’s opinion on the notion of a body that would, independent body that would in fact provide guidance, both in terms of what constitutes acceptable care and then what constitutes affordable care at a national level, and what you think about that kind of
body and also the degree to which you would be willing to share your data to help inform the kinds of decisions that a body like this would be in a position to make?

**MS VAN DER BERGH** So we have already shared out data with the Department of Health because under the millennium development goals there was a big drive for Department of Health to actually try and collate a total picture of South Africa, so, I think, in that particular field, we really made some advancements in actually [indistinct] as to what data they needed and how to actually provide that, and in addition to that, we have an ethics committee and we have the structure that I described to you before, and these matters come up from time to time, including these discussions with the medical schemes, as these questions arise, and I think it’s a very important progression in our system for us to pursue that and to understand that, and there are also end of life decisions that are increasingly becoming considerations that we have to all understand and evolve as we go forward. So we would support that those discussions, those deliberations and us building a structure around that process.

**PROF FONN** So you would be happy to be part of that process and contribute to that kind of intervention if ...

**MS VAN DER BERGH** [indistinct] again to the point about independent practitioners, because the doctors have to come to that table, too, and sometimes the scheme is
engaging with us on a decision that a doctor and the patient’s family are making, and we need all of the parties to be going on this journey, as we go forward, it’s often difficult for us to intervene between a relationship between a doctor and his patient and their family.

PROF FONN I wanted to make the point that we are sometimes arbitrary around when we use which denominators. Sometimes we use total population and sometimes we use the medically insured population, and that’s fine, as long as you just say which one you’re using, so it’s very clear. Would you agree with me that when we start talking about South African burden of disease, suddenly we talk about total population, and in fact the majority of the burden of disease is borne, first of all, all of our data is significantly skewed by HIV in terms of our burden of disease and in terms of our years of life lost, although this is obviously reversing, but in fact a very significant amount of the burden of disease that we keep talking about is borne by those people, disproportionately by those people who are not in the medically insured population.

Would you agree with that?

MR CHILDS Is that a question to me, professor?

PROF FONN I think so.
MS DA COSTA  Thanks, Professor Fonn, as I was thinking about it, I think, Barry, you’re best placed.

MR CHILDS  Yes. So, yes, I agree with you that sometimes denominator’s and emotors are confused and the right thing to do is to say which one you’re talking about when you’re showing a piece of work. Yes, when you’re referring to burden of disease, let’s say, for instance, the calculations that I did in this piece of analysis, it’s looking specifically at the burden of disease and the changes in the burden of disease in the private sector, not in the public sector. The good burden of disease data is quite difficult to get in the public sector at a systematic level, but if you ask me my opinion, whether there’s a difference in the burden of disease, a disproportionate difference in the burden of disease between the public sector and the private sector, I would say, yes.

PROF FONN  I think it’s just relevant when we talk about doctors loads, because that’s when we sort of forget about which burden of disease we’re talking about, but ...

MR BISHOP  Professor Fonn, if I could add, possibly, I think it’s also to bear in mind of course that the ones that don't differentiate would be our high instance of trauma, road accidents, be they, and oncology and possibly lifestyle diseases. So you’re quite right. I mean, the burden of disease for the total population and the medically insured is different but each one has different elements.
PROF FONN  I think you’re probably wrong but I think we both have to go back and check our sources. I think violence and lifestyle diseases are disproportionately represented in those people who are not necessarily medically insured, but we can both go back and check. I was very interested, Mr Norton, in your point about parallel importation and the potentials of using the law. I think most of that is governed under international trade agreements, and I would be delighted if you would expend some of your intellectual and other time in addressing the possibilities for South Africa to exploit more of those possibilities, because I think it could make a difference for the public sector and the private sector, both in terms of the international property rights and the trade agreements, and so if you wanted to spend some time doing that, I think you could benefit many of us.

MR NORTON  We’d be delighted to assist on that and I think you’re absolutely right, it’s a very complex area of law, but we’d be happy to, I think, do a follow up paper on that.

PROF FONN  Then just in relation to your presentation, I think in relation to the points you made about the UK inquiry and the degree to which regulation is or isn't instructive or useful or not, take all your points on board. I think what’s also important to remember about those kinds of comparisons, and I’d be interested to know if you
agree with me, is the degree to which the public sector both in the UK and the OECD countries operate with the public sector, one, having the data, and therefore knowing the costs, and then being a significant purchaser of private sector healthcare and therefore creating a particularly kind of counter balance and therefore it might, in those circumstances have less of a role for regulation, whereas where you don't have a public sector doing that, there might in fact be more of a need.

**MS DA COSTA** Thank you, Professor Fonn. Just with respect to the operations of the UK market, we obviously have the bulk of our patients are still private patients, so those contractual agreements are between BMI Healthcare and the individual funders. We do contract with the NHS, the NHS is as much as 40% of our patient volume now and that is a price that is set by the NHS, in fact the NHS has a regulator called the Monitor and they regulate publicly funded prices, whether it is delivered in the private sector or in the public sector, and it kind of takes me to a question that was posed earlier with respect to Anthony Norton not expanding on regions that have regulated privately funded and privately delivered healthcare, and in truth I'm still to come across a region that has done that. Our experience in terms of regulation has been regulation of publicly funded, whether it is privately delivered or publicly delivered, that tends to be the domain of it. The inquiry in the UK was quite specific to the contractual arrangements within the private sector, so privately funded, privately delivered.
**PROF FONN** Thanks for that clarification. There were some questions that come out of other submissions. Your managers of your individual hospitals, do they have service level agreements or whatever you call them, but things they have to do and included in that, is there anything to do with levels of occupancy of your hospitals?

**MS DA COSTA** Thank you for the question. So our hospital managers, just like the executives at the table, would have a scorecard and that scorecard monitors the objectives that you want to achieve for the year for the purposes of getting an incentive at the end of the year, over and above your salary. It can contribute up to a third of their package. Hospital managers have a scorecard of approximately twenty-five points on that scorecard, inclusive on that, there are issues such as quality, their financial metrics, there’s transformation metrics, there isn't a direct occupancy one but there is a patient volume, which is effectively the same thing. I can confirm that it is one of the twenty-five metrics, and quality, for example, would be double the weighting you would have of that metric. Thank you.

**PROF FONN** I wanted to come to your point about what would make the most difference and that the bottleneck of doctors is the big problem. First of all this is an international phenomenon, it’s not a South African phenomenon, and I suppose I was surprised, given the reliance on the doctor, and I wondered quite why we were there. It
seems to me that because it’s an international problem, it’s unclear to me how South Africa could conceivably, in the short term, produce enough doctors where we have countries of much more resources who seem unable to do that, and also that the notion of task sharing, the notion of alternative care, the role of clinical associates, the role of primary healthcare nurses, all of these seem to me to be innovations that, well, they’re not even innovations, they are standards in many countries in the world, and they offer a realistic high quality comparable solution, and particularly for the kinds of high burden diseases that we have. There have been studies that have shown that nurse practitioners in the US can provide comprehensive, comparable care for diabetes, for hypertension, for a whole number of things, and so I think there’s space in the market to start thinking through much creatively about the appropriate deployment of the levels of care within the system, and so I was wondering why you were so sure that the solution lay in producing more doctors.

**MS DA COSTA** Thank you, Professor Fonn. So firstly, I'm not absolutely certain. The longer term solution, in my opinion, is a function of the doctors, just because of the acute shortage, but I totally appreciate that there’s no magic bullet in the short term to ensure that we have an output of a whole lot of doctors, but in comparing our issues to global issues, I mean, ours is infinitely more acute and we’ve got to start some time in terms of opening up to increasing training, so that’s one thing, but I totally support
what you’re saying, task shifting, be that, and I'm pretty sure Dena and Mark can expand on this, but that is something that we absolutely support. I'm just going to rely on Dena, Mark, which one of you is going to take this, I'm just going to rely on the experts in terms of the art of the possible.

**MS VAN DER BERGH** Yes, I want to just support what you’ve said and I think part of our frustration that we've probably been voicing today is that the regulatory inhibitors of the very model that you’re proposing is what frustrates us, so the ability for us to bring in a healthcare worker of a different category, there’s new qualifications that’s very encouraging that the kind of professionals are being produced by the system and yet we don't have the ability to utilise a different type of doctor. I think there’s a lot of room for that. We've certainly applied all of that in the areas where we can, so in the field of nursing, we've done task changes, we’re using professional nurses for more professional work and being able to bring in different categories of staff in the world of the pharmacy, we've taken our pharmacists from just being in the world of the dispensary and the pharmacy in the hospital out into the ward to do more monitoring, to do more discussions with doctors, and to provide the levels of care that we want to, and so [indistinct] it’s in our domain we've been able to extend that, but even with all of those, the issues of the scope of practise are being frustrated in this process. So we would support the expansion and the development of that work.
PROF FONN  Maybe just while we’re on nurses, one of the, sorry, Judge.

JUSTICE NGCOBO  I just wanted to follow up. Have you raised this issue of employing doctors before, I mean, prior to this inquiry?

MS VAN DER BERGH  We raised it numerous times, both at an industry level and at an individual level, each of the groups.

JUSTICE NGCOBO  Have you taken the trouble?

MS VAN DER BERGH  Beg your pardon?

JUSTICE NGCOBO  Have you taken the trouble to research why there is a shortage?

MS VAN DER BERGH  You mean a shortage of doctors?

JUSTICE NGCOBO  Yes.

MS VAN DER BERGH  Have we taken the trouble to research why.

JUSTICE NGCOBO  Yes.

MS VAN DER BERGH  We have take, I believe we have, I'm not sure if understand your question, though, in terms of [indistinct] particular area?
JUSTICE NGCOBO  Let me put it this way. Are you able to tell us what causes the shortage? Is it the training, insufficient training institutions, or is it more than that? Because it is one thing to talk about we need more doctors to work at your hospital, but what is the root cause of this, so that if it is addressed, the root cause of it can be addressed?

MR NORTON  Chair, perhaps I could have a go at just summarising some of the factors that I discussed with the Netcare people over the last few months, and I don't purport that this is a perfect answer, but I think it summarises some of the factors. I think, Chair, it’s a combination of factors, and I don't think it’s just one. I think it’s limited training. We said there are eight public universities, there are no private education facilities for doctors, so there’s a limited number of doctors that our public institutions can produce every year, and our population has been growing commensurately and the number of doctors that we product hasn’t been growing proportionately with the growth in population, so I think that's one factor. Second is immigration. At one period we did have quite a large portion of immigration of doctors, so I think that’s also a factor, that we lost a lot of skilled doctors at one point. I think that’s been rectified, but there was, immigration was certainly a factor. I think it’s also part of the trend, Chair, that not as many people are going to specialities, as perhaps was once the case, so there’s also not as many people necessarily converting to
the specialties, as was previously the case. So I think it’s a range of factors, Chair, I don't think it’s necessarily just one, and I think also some people are maybe not joining the profession as much as they used to as well, but I think the biggest issue, Chair, is that we only produce so many, our educational institutions can only produce so many doctors, and the population has grown and we’re not keeping up with the population growth, and burden of disease has also grown commensurately. So I think it’s a range of factors, Chair.

JUSTICE NGCOBO Your hospital trained nurses, right, how many do you train a year?

MS DA COSTA Chair, we train approximately three and a half thousand nurses per annum.

JUSTICE NGCOBO What about the other hospital group, Mediclinic, do they train?

MS DA COSTA From the presentation yesterday there was reference to training by both parties, the numbers would have differed but there was reference to training.

JUSTICE NGCOBO And Life Group?

MS DA COSTA I'm looking to Dena for some affirmation here.
JUSTICE NGCOBO  And all three major hospital groups do train nurses, right?

MS DA COSTA  Yes, that’s how our understanding.

JUSTICE NGCOBO  But that too seems to be inadequate.

MS DA COSTA  So it might not be perfect but it’s better than zero, Chair.

JUSTICE NGCOBO  No, no, no, no, I'm not criticising you, I'm trying to look at what is the root cause of this problem because we can keep on training nurses but if we keep on training them and we lose them, losing them to other countries. I mean, one of the points that’s being made here is that some of them leave the country to go to the US, not the US, the UK because perhaps the pay is better there.

MS DA COSTA  Chair, if I can just focus specifically on doctors, certainly within our own hospital portfolio I think that there would have been a trained on immigration some ten odd years back but it’s not something that’s been a major issue, certainly over the last, I’d say, five to eight years. If you keep track of all the doctors that have left our network, where they’ve been moving or not moving, if they’ve retired, if they’ve passed away, if they’ve moved overseas, and immigration isn't a big issue.

JUSTICE NGCOBO  I'm just concerned that if we focus on hospital having to train as if that is the answer, whereas there are other considerations that should be borne in
mind so that when you address the problem, you know precisely what the problems are so that we can try and address these problems, or at least the authorities, those who are responsible for dealing with them.

**MS DA COSTA**  Chair, just to add to what Anthony has said, I think the issue here has just been not keeping up the demand, so I think that is number one factor, and it’s not necessarily that private hospitals per se should train doctors, it’s just is there a possibility of attracting private medical education in the country. I know, for example, there was a large Indian medical school operator called Moneypal, and looking at the South African market a little while ago, so we’re not necessarily saying it’s a hospital group, but just any international player with expertise in this space is that something worth considering. Thank you, Chair.

**JUSTICE NGCOBO**  Yes, thank you.

**PROF FONN**  There’ve been two instances where we've been told about producing reports on quality of care. The one, I think, was yesterday, well anyway, very recently by the provinces, who said that, I wrote it down, they said, we cannot make quality reports public because we are scared we’ll be sued if the province is exposing that a Netcare or a Mediclinic or a Life Hospital has poor quality. That’s what they told us. Then the other instance was in relation to, I think it was the Chair of the Board of
Trustees of Discovery, who spoke about a period when they were going to make public some comparative quality measures on hospitals, and I think, I stand corrected, I can't remember exactly what he said, but something like, there was a huge furore, I think, or something that he said, and we were forced to stop this process. So who are you planning to sue and why should they be so scared of you?

**MS VAN DER BERGH** I’ll respond to both of those statements. The first one about being sued, I [indistinct] overall if I just listened to your question, it comes back to the point about like for like comparisons, so that it’s fine to put data out into the public domain, as long as it’s accurately reflecting the actual quality of care. So if I go back to the furore around the Discovery issue, they had taken a set of data, they had run the data through various methods, and they had come up with a report which they actually did, they published it on the website for a short period of time, and in those days, this is probably seven or eight years ago there was neither [indistinct] consultation in that process and the data went live and we had the opportunity to see it when it was already in the public domain and there were several inaccuracies and I recall in my own world that there was a small community emergency centre that was considered the best centre in the country for trauma and emergency care, and they had a very low mortality rate, that’s because they closed their doors at ten o’clock and didn’t have any trauma, and so the risk of having that data out in the public domain could [indistinct] that a member of
the community would drive to this little hospital and firstly find it closed at ten o’clock, and secondly, yes, the mortality was accurately the lowest mortality but the work hadn’t been done to ensure that the data, so that a person in the public domain would make the right choice about where to seek emergency care, and so we did put a huge furore out into the market and we did ask them to withdraw that information from the public domain until such time as it was accurate. More recently we have had much more engagement prior to it going into public domain and that’s a more healthy process and I think even the member of the Discovery Executive would agree that we’re in a better position now for us to collectively do that work going forward.

**JUSTICE NGCOBO** I think what was most disturbing was the fact that officials whose duty it is to make this information known, fear, I mean, it is the element of fear that I do find quite disturbing, whatever the reason may be, because they say we feared being sued. Whether this is a reality or what, it’s something that is not desirable. The concern about accurate information being out there, there’s no question about that, but the fear that people would not even publish things such as this, for example, which is contained in this judgement of the Supreme Court of Appeal, where in one hospital a surgical swab was left in a patient’s stomach. See, those are, when these sorts of things do happen, it’s something that is quite concerning. Equally true, though, and this is what the stakeholders have insisted, and rightly so, the accuracy of the information,
because of the huge danger that may be there to the good name of the particular facility if wrong information was there. How does one balance that against the fear, because those individuals seem to have just the fear of just doing anything?

**MR NORTON** Chair, can I possibly just respond to the official issue. I unfortunately didn’t hear those comments from those particular officials, and I don't know if they were referring to a Netcare hospital or to private hospitals more generally, I mean, certainly, Chair ...

**JUSTICE NGCOBO** I think they were just talking generally.

**MR NORTON** I think certainly, Chair, I mean, we would be concerned if they felt concerned about doing their official duties because of any pressure that was brought to bear on them, or concern that the private hospitals would take some sort of litigation against them. I certainly don't think that that’s Netcare’s policy. I mean, I can't comment on these particular incidents because, to be honest, we don't have any facts around it, but I would be very surprised if that was an official Netcare position on these types of issues.

**PROF FONN** Is employing agency nurses cheaper than employing your own nurses?

**MS VAN DER BERGH** No, in fact it’s more expensive and significant [indistinct].
**PROF FONN** I am curious to know in the nursing cost what drives the nursing costs because clearly all hospitals are using a lot of agency nurses and I also understand that it’s hard to know who you need where, when, because occupancy rates change, but it is an issue that if it is more expensive and you have to use them, how do you optimise that and what is driving all these nursing costs.

**MS VAN DER BERGH** Would you like us to cover [indistinct] or do you want more information on ...?

**PROF FONN** What we have asked the other people, the other players for is if they’ve got, because apparently you have this, you describe the sophisticated system of who you need where and when and the other hospitals also did, and as a result they said they could in fact produce a document indicating what proportion were agency nurses. So if you have something similar that would be useful.

**MS VAN DER BERGH** Yes, we do. We will be happy to do that.

**PROF FONN** Thank you. The other question, the other thing we were told by nurses who are now working in the private sector, so these I understand are specialist nurses, so they’re either colostomy nurses or wound care nurses or these kinds of nurses, and they say that they used to be employed in hospital in full time employment and you got
rid of them all to save costs. Have you?

**MS VAN DER BERGH** I'm not aware [indistinct] different models of implementing the care that is required and one of the models is that [indistinct] most practitioners can come in or we've actually in fact created a wound care clinic and so that patients can use that wound care clinic on an out patient basis, so rather than just by [indistinct] in a hospital it’s actually available to that community for [indistinct] hospital care as well.

So there are different models. Sometimes a very good nurse, wound care nurse will want to set up a clinic and we will contract with her to do that, but it’s not the same model everywhere either.

**PROF FONN** So you systematically have not been driving them out of the system.

**MR BISHOP** Professor Fonn, if I can add, in fact this issue comes up with schemes, one of the queries they do not want is that when a patient’s in a hospital and required advanced wound care, it’s a requirement for us to be able to deliver that, and our nursing staff would be required and trained to do that, and they certainly are. What has been seen at times is that these wound care nurse practitioners might be working inside the hospital either on a contracted basis or sometimes not contracted by the hospital, and that is a different issue, but our undertaking to schemes is that we provide this
service and I can certainly tell you we would never chase such nurses away, those kinds of skills would be required.

**PROF FONN** Yes, so I want to just check one thing again, and that is that if it is the case that doctors are preferentially discharging their patients from the operating theatre to ICU or high care, this is a doctor preference and not because you do not have the ability, now clearly some people have to go to high care, I'm not talking about those, that this is a doctor preference and it is not about the fact that your general wards cannot receive a patient from theatre.

**MR BISHOP** Certainly it would be based on a doctor’s treatment regimen where he wants a patient sent, but there is no call for the fact that patients would have to be done. I made this comment is that the first time this was ever raised with me was in 1996 by a managed care organisation. This is not a recent anecdotal comment. The reality is that our nurses are well qualified and well able to deal with that patient, based on the areas that they’re in, and it would be a doctor.

**PROF FONN** The last question has to do with remuneration of work outside of the public sector. You will know that there are doctors who are in the full time employ of the public sector and that some of these doctors have no agreement to work outside of that and should not, and others of them have sanctioned agreements to work outside of
the public sector for remuneration in their own practices or in working as well in your hospitals, using your hospitals. Do you have these doctors working in your hospitals, do you keep any records of them, do you see it as your responsibility in any way to monitor that in fact they're not overstaying their allotted time. I understand that the contract is between them and their employer and that you are a facility and not an employer, but I'm curious to know your attitude towards this. Related to this is that for at least a proportion and sometimes all the doctors in some province, they may only do this outside of working hours. In those provinces is it the case that your facilities are then open at other hours, your theatres run at, I don't know what time, four o’clock in the morning or six o’clock at night to facilitate their working there.

**MS DA COSTA** Thank you, Professor Fonn. I don't have the general knowledge as to what our exposure might be across the group, I can share with you that we have some private public partnerships and in particular in those collocation hospitals there would be exposure, we’re speaking about Pelonomi Hospital and Universitas, in particular, and I understand that one of the things we have introduced is a requirement for the doctor to prove to us that he has received approval from the academic unit he’s operating in or she’s operating in, just to ensure that there is full disclosure, that the doctor is splitting practice, whatever that might be. So that is something we’re putting
into practise. If you would like any further information we can gladly help you with that.

PROF FONN I'm just curious what your legal team thinks about the legal responsibility that you might or might not hold in response to facilitating their ability to, I think it’s probably fraud, I'm not sure quite, I'm no lawyer, but do you have any responsibility in, do you have any exposure in that regard?

ADV UNTERHALTER I must say I haven’t thought about this in any detail. I mean, as you indicate, there are two different contractual relationships in play and one doesn't give rise to a supervisory duty over the other. Whether there is some potential inducement to breach of contract, one would have to think about but I wouldn’t have thought that there’s any inducement to breach, there is simply an ability to offer the use of facilities, and it’s for the person who uses them to ensure that they are doing so consistent with their other contractual obligations. That would be my first blush response but happy to think about it a little bit more.

JUSTICE NGCOBO Unless of course, you know, in coming to work for the facility they are committing some kind of a wrong that you’re aware of and you nevertheless do nothing about that. That may be one of the circumstances.
ADV UNTERHALTER  If there was some joint tortfeasor situation, but I, as I say, if you make your facility available but you don't actually employ them, you’re not, as it were, inducing them to breach their contract to say I have a facility, use it if you can and it’s competent for you to do so.

JUSTICE NGCOBO  We were told that it is not inconceivable that you would have a doctor working in a facility during the day and that in the evening he or she works at another facility. Is that something that Netcare would sanction?

MS DA COSTA  Chair, can I ask just a clarification on that at? Are you just referring to in general a doctor splitting their practice, operating in more than one hospital, is that the question?

JUSTICE NGCOBO  I think the term they use in these matters is moonlighting. I don't know whether that applies to nurses only or it also applies to doctors, where you work somewhere else during the day and then in the evening you work somewhere else, or you may be working for Netcare during the day and then work somewhere else.

MS DA COSTA  Chair, there are no restrictions in doctors having admitting privileges in more than one facility and it’s not uncommon for a doctor that has an admitting privilege in a Netcare hospital to have one in a competing hospital nearby. So we call
it splitting, where they split their practice between different sites, maybe the sites are far away, maybe they’re close, but they might just have patient bases in different areas.

JUSTICE NGCOBO What about those who are employed by the public sector, those would be in full term employment, wouldn’t they, I assume a doctor who is in the public sector would be employed full time?

MS DA COSTA Chair, I must admit that I actually don't, I've never heard of this and I don't have enough information on it and if you don't mind we will gladly go back and explore it within our hospitals and give you some feedback, but I'm drawing a blank.

JUSTICE NGCOBO I was just curious to know, if a person has been working in his or her ordinary job from morning until five or whatever the time he or she finishes, thereafter in the evening he then goes to another facility where he probably works until about eleven or twelve in the evening, depending on the time, and whether or not that doctor would have the required mental alertness to be able to attend to a patient. Let me put it this way, would you be concerned about that?

MS DA COSTA Yes, absolutely, and, Chair, I think a similar question was asked yesterday from a different angle, and that was with respect to nursing, and our own thoughts internally is just to think about this the way the airline industry does it, where
you’ve actually got to log, you’ve got to register your hours in some format just to prevent this, because obviously that is a concern in terms of patient care or patient outcomes, absolutely.

**JUSTICE NGCOBO**  Yes, very well.

**DR BHENGU**  Thank you, Judge. Thank you very much. I just want to start with a follow up question that I think both from Dr Nkonki and Prof Fonn, regarding the capital intensive specialities like radiology and pathology, what is the financial model? Is it, from your side, is it a straight lease for space or is there a component that’s linked to the revenues?

**MS DA COSTA**  So Dr Bhengu, I can confirm that it’s just a straight lease. There’s arms length, nothing further.

**DR BHENGU**  Thank you. In your otherwise comprehensive presentation, I missed comment completely about Prime Cure or Medicross, which for a Competition Inquiry would seem to be significant if it leads to on two levels, it’s the vertical relationship with your main business and surely some of the questions that are important is to understand if doctors working in these general practices are at liberty to refer to your competition or the expectations that all referrals will be to Netcare? Obviously the next
one would be whether there are set targets in terms of volumes. So it’s really just a question like that. Is there any reason that we felt there’s no need to touch on ...?

MS DA COSTA Certainly. I'm going to take the second question first and then let Anthony cover the first one. With respect to Medicross, there are absolutely no requirements in terms of referrals into Netcare hospitals. We actually do have some data in terms of which GPs refer in to specialists in Netcare hospitals and I can confirm that we’re talking single digits out of the Medicross primary care facilities.

MR NORTON Dr Bhengu, I think just to give you some measure of comfort on these issues, certainly when Netcare acquired both Prime Cure and Medicross, both transactions were thoroughly scrutinised by the competition authorities when those transactions were done and were cleared on the basis that it didn’t present any significant competition concerns. I think the reason why in this presentation we didn’t deal with that comprehensively is we felt that the primary emphasis should be around the hospital services and those were more managed care and the sort of, and the GP based services and hence why there wasn’t much emphasis in this presentation, but we’d be very happy to provide you any more detailed information if you would like.

DR BHENGU Okay, no, I'm happy with your response, that’s fine. Very quick ones, I assume. Mr Bishop, this would be yours. You made reference that the relationship
between Netcare and even the smaller schemes like self administered schemes and I think, well any of the smaller schemes, the balance is just as it is with Discovery. Are we sure that when we look at data, going forward, we will find no correlation between the size of a scheme and the tariffs that they’re able to negotiate with yourself?

**MR BISHOP** Thank you, Dr Bhengu. The first part is that obviously our submissions include our bargaining paper and this is covered by our expert opinion by Dr Peter Davis, the ex deputy commissioner for the commission in the UK, and he’ll be talking on this on the 15th of April, but I would stress that it’s our relationships that are solid and the same across and how we engage with each funder is based on how that funder chooses to engage with us. We like to meet everybody directly.

**DR BHENGU** When we had Discovery Health, I asked the chief executive here, basically that data is such an important tool, I think I used weapon and he insisted it’s an asset, but in tariff negotiations, now, from what we’re hearing, the balance in terms of power is pretty much even. If the panel were to recommend that data, ahead of tariff negotiations, should be shared openly, to what extent would that disempower the funders? Would it completely tilt the balance in your favour?

**MR BISHOP** Pardon me, can I just be sure? Are you saying that they share the data with us prior to the meeting, and which data that would be?
DR BHENGU  Yes, you’re talking about utilisation data based on maybe the previous year, and all other related cost data, the data that you required, really, at least as things stand, that they work with.

MR BISHOP  There is a, and I think it’s the same one, when you’re negotiating with any scheme, the reality is that they have data that we don't have. For instance, they’ve got a comparability across all the other groups and data, we never see that, we don't know what it is. By the same token inside our data we’re able to analyse them versus all the other schemes. So I would say there’s pretty much a match in what you’re able to use and we can look at the utilisation of each scheme as it pertains to ourselves. They can see that as it pertains to us versus the others. So I'm quite content with the level of data that we’re both able to share, and it’s pretty much a match when it comes down to analysis. I go further that the small schemes have come a long way in being able to analyse this through the use of consulting firms, such as Insight, which sits at this table, who advise many of these schemes on their abilities to analyse data and engage with us.

MS DA COSTA  Sorry, Dr Bhengu, I do want to just clarify one point, because you asked two questions. One, you asked if Discovery has a balance negotiating power,
that was the one question, and the two was data. Did I misunderstand?

**DR BHENGU** No, it was really in the context I was referring to, a discussion we had with them, but it was the question that Mark tackled. Regarding the one question I asked specialists earlier, I think it was SASA, is if there are any funder rules that on the ground prohibit Netcare or generally hospitals from providing the kind of quality care that they believe they should. I’ll leave that open and if there are, which ones are those and how would industry need to resolve it to make sure that they stop hindering this?

**MR BISHOP** I would state that PMBs have pretty much covered this for patients.

**DR BHENGU** No, I'm thinking more like quality.

**MR BISHOP** Quality issues.

**DR BHENGU** Yes.

**MS VAN DER BERGH** I think anecdotally there might be some referral to some of the restrictions to some of the rules that have been in place in terms of benefit and benefit design, and whether we would pay for a certain drug or not, but I would argue that most of those have been based on very sound research and that in essence they’ve supported a better and higher quality of care and that occasionally there may be people who disagree, but, you know, I would like to have access to a particular product for
pain, a new produce was launched for pain, and, you know, everyone wants to use it for everything but then some restrictions were put in place and actually through proper research we put in systems to ensure it’s used properly. So I don't have a sense that there are big issues. I think sometimes it’s a new issue and it needs to have the research and the consideration, but mostly if they’re historical or those issues are in place, they’ve normally been based on a lot of good research before a [indistinct] would say that and before we would agree to implement that measure in our particular facility.

DR BHENGU  I was thinking more process issues than product. The example that I put to them was the requirement that patients must come in on the day of surgery, what, for example, it meant for them regarding premed rounds and stuff like that. That’s more or less the type of process issue I'm talking about.

MR CHILDS  I don't know if we have any of those. I suppose more likely we’re able to engage when it might be a new thing around technology, where they’re not, they don't see the benefit in the beginning, but then that would become a process and there’d usually be a period of time in which we would engage properly, that there’d probably about a fair amount of evidence to support it. Robotics would be a good example. Our general impression is quite often schemes will adopt individually and then tend to
follow once they feel they’ve all done their homework, but I wouldn’t say that there’s specifically a process issue that leaps out at me right now.

DR BHENGU  Okay.

MS VAN DER BERGH  But I do agree, I mean, I know that SASA has raised this. This is the anaesthetists, so for those of you that don't know who SASA is, the anaesthetists do have time pressures to actually do those assessments on the day of surgery and, so those processes, I do understand the pressure that they have in terms of ...

DR BHENGU  But from the hospital side, it’s ...

MS VAN DER BERGH  From the hospital side, and they do, they have [indistinct] ways to deal with that, but it is, it has, and I think [indistinct] large they’ve got good processes to deal with it but it has put additional pressure on that process, and the more that is required for more complicated cases, you would have to motivate and there are different inhibitors of that process.

DR BHENGU  Still to Ms van der Bergh, regarding the morbidity and mortality meetings and other CME programmes on the ground, are doctors contractually bound to attend these or is it on the basis of when they want?
**MS VAN DER BERGH** They’re not contractually bound to unless if there’s a case that is [indistinct] case, they are requested to attend that particular hearing, they don't have to come to [indistinct] but if there is a particular case that is being discussed at the mortality and morbidity meeting, they would be required to come. I've never had an experience where they would refuse to come although they [indistinct] as opposed to, you know, they’re still invited to come. We haven’t had the experience that they wouldn’t be willing because morbidity and mortality meetings, as you know, are learning, are part of that process and that culture prevails in those meetings.

**DR BHENGU** What’s the compliance record when they’re invited? Because the [indistinct].

**MS VAN DER BERGH** I’d say it’s over ninety percent.

**DR BHENGU** That’s fine. I'm assuming that they don't get paid for attending.

**MS VAN DER BERGH** No, they don't.

**DR BHENGU** Okay. The other issue here that I just want to know, within Netcare do you have just one type of hospital doctor contracting model in terms of their availability, in terms of providing service? I'm thinking here, I mean, doctors working
in Milpark, is there a same type of arrangement with doctors who are at Rand Clinic or Parklane, for example?

**MS VAN DER BERGH**  As far as I know, yes, we have an admitting privileges document that has a code attached to that, so those [indistinct] principles are the same everywhere.

**DR BHENGU**  What about, is there no hospital where they’re required to be on the premises, not just on call?

**MS VAN DER BERGH**  Oh, yes, but those are arrangements around that the doctors organise themselves around in terms of, you’re talking about Milpark will have a neurosurgeon available, they'd have a trauma surgeon available, they’ll have, that’s been, we do that in consultation with them to make sure that in fact we have the kind of cover for a big motor vehicle accident that comes into Milpark for you to get the right [indistinct] speciality.

**DR BHENGU**  But what does that mean? Does it mean in other hospitals, I'm aware this is not necessarily a Netcare issue, but what does that mean? Does it mean in other hospitals the need for such certainty of emergency service is less important?
**MS VAN DER BERGH**  Well, that’s why there is a whole process of categorising trauma centres in terms of level one, level two, level three, and that’s made available to the public so that you’re aware that when you have a certain type of procedure that needs level one trauma care, that you actually use a facility that is accredited by the trauma society, which is an independent body for level one trauma, and those requirements are different to, for example, that hospital that I mentioned, that is a community hospital that would not offer a major accident service. So that would advertise itself as an appropriate level.

**DR BHENGU**  Is there a different payment arrangement, does the hospital have to provide for the downtime but while they have to be on the premises, or it still retains a completely independent practise, if the doc is there twenty-four hours and they don't see a patient, that’s their problem or are there any guarantees that ensure that they’re on the ground all the time?

**MS VAN DER BERGH**  There’s a staffing [indistinct] that the practice agrees to as part of that [indistinct].

**DR BHENGU**  Oh, so it’s a practice issue.

**MS VAN DER BERGH**  Yes.
DR BHENGU  Okay, thanks. The ICU, you think the ICU, the model should be the same, should there be a, the intensivist, should it be more broadly accepted or it should still be each doctor working for their patient?

MS VAN DER BERGH  I think the model that certainly I would support is a combination where we have intensivist support and the doctors who have the [indistinct] relationship with the patient also continue to do that. We do have some models of a closed ICU. I know some models support that. We don't have enough intensivists to do that. There are other models of hospitalists and other models that we've discussed with the intensivist society and I think there’s room to explore what we could do in that field to make it both efficient and higher levels of supervision by doctors that are suitably qualified.

DR BHENGU  What’s Netcare’s attitude towards doctors who have rooms, have got privileges in terms of rooms but choose to also do procedures in their rooms? Is that supported, is it frowned upon? One can see how the, in competition with you in some levels.

MS VAN DER BERGH  Are you referring, what sort of procedures are you referring to?
**DR BHENGU**  I'm a general surgeon and I have a gastroscope in my rooms because then Discovery will pay me more if I don't use your facility, that type of ...

**MR NORTON**  Dr Bhengu, we do have a number of those cases where doctors do that. So there’s no hard and fast rule on this, but there’s no restraint. There could not be a restraint on his practice, no.

**DR BHENGU**  We've heard a lot that seems to be going well. You say you get 90% of the doctors attending your CME meetings or whatever, and there is compliance generally. Why would you still want to employ doctors? What’s the missing link that you think will be addressed by employing doctors?

**MS VAN DER BERGH**  I don't think we are supporting the fact that we want to employ all the doctors, I think what we would like to be able to do is employ doctors in selected areas where that type of requirement is necessary. So in the model that you spoke of earlier, in the intensive care unit, is there room for us to employ a doctor. At the moment if we wanted to employ a doctor to add to the service of that unit, we wouldn’t be allowed to employ a single doctor to supervise care and to, so the emergency unit, you know, we wouldn’t even need to employ [indistinct] in them in that case, but the fact that says we may not employ any to supervise [indistinct] and to deal with other doctors in that process is I think what would be our primary initial
model, and then of course, as Melanie has demonstrated in her examples, there may be particular models of care why we want to offer a service like the cataract service or the [indistinct] efficiently and in that model it would be preferable for us to have a model in which we would employ doctors so that we can deliver that particular [indistinct] of work in a much more efficient way and be a way of how many procedures they do, what they do and how we actually manage that process, when we make that commitment together with the doctors. I think that would be where we would envisage that work.

**DR BHENGU** Regarding doctor training, we have asked the HPCSA what the issue is and if I recall, Dr [Klape] said there actually is nothing that stops hospitals from employing doctors or training doctors, but there is a process of accreditation. Are you familiar with that?

**MS DA COSTA** I personally don't have all of the experience but we have the one example of University of Johannesburg that we can share with you. We thought there was an opportunity to partner UJ in undergraduate training, they don't have a dedicated medical school, the university council approved it. Before approaching the Minister of Education, they went to the province and my understanding is that at the provincial level it got blocked, so I do know that there’ve been initiatives in KZN more recently
that hit the press with respect to the Monipol Group in particular, looking, engaging the premier in terms of setting up medical schools, I know that our own CEO would have some history around this because I think a few years ago, before my tenure at Netcare there was some engagement with the departments, the relevant departments on this topic. So to date no one has succeeded. What the bottlenecks or the constraints are, I cannot elaborate on right now but will gladly look into that.

**MR CHILDS** Dr Bhengu, you’re absolutely right. From a legal perspective you’re correct. There’s no absolute legal bar which says that private entities can't train doctors, you’re right, they have to apply for accreditation through the Department of Education, and in certain instances, for professional training for doctors, have to get permission from the Health Professions Council as well. There’ve been some initiatives that specialists at Netcare had wanted to do to train other doctors in various specialities and there’ve been some log jams with Health Professions Council in getting the requisite permission for that. So, you’re right, as a matter of principle there’s no absolute legal bar, and you’re absolutely correct that it’s principally a question of getting accreditation, but getting accreditation in practice is a far more difficult and cumbersome thing that I think in theory than it may appear to be.
DR BHENGU  No, it certainly was.

JUSTICE NGCOBO  Can I just make a follow up. Does Netcare conduct in house training for doctors and specialists?

MR NORTON  Not Netcare, per se, Chair, but some of the specialists who work at Netcare facilities have from time to time approached the Health Professions Council to conduct further doctor training and doctors, sort of, particularly in their field of specialisation, but not Netcare, per se, but doctors who work within Netcare facilities.

JUSTICE NGCOBO  And for that they need to go to the council.

MR NORTON  Correct.

JUSTICE NGCOBO  Okay, but do they have to go the higher education?

MR NORTON  It depends on the nature of the training, Chair.

JUSTICE NGCOBO  But the kind that you’re talking about, is it ...?

MR NORTON  No, that you need permission from the Health Professions Council.

JUSTICE NGCOBO  Have those been granted before?

MR NORTON  Chair, my understanding of the one case that I'm aware of, and I can't
CLAIM TO BE AN EXPERT IN THIS AREA, BUT I'M AWARE OF ONE PARTICULAR INSTANCE WHERE ONE OF THE SPECIALISTS AT NETCARE WANTED TO DO THIS TYPE OF TRAINING AND I THINK RAN INTO DIFFicultIES WITH HEALTH PROFESSIONS COUNCIL IN GETTING THE REQUISITE PERMISSION, BUT I CAN TELL YOU AUTHORITATIVELY THAT THAT’S ALWAYS THE CASE, THOUGHT. I'M JUST AWARE OF ONE PARTICULAR INSTANCE.

DR BHENGU Thank you. I just want to move quickly to probably a part that hasn’t been covered much with other hospitals, but you indicated that you do have partnerships regarding the various models. You went into triple P's and we also made reference to empowerment models. This is obviously from the angle of new entrants. We spoke to the provinces on licensing, a great deal. KZN said they are sitting with seventy-six issued licences that are not developed. Gauteng, we raise the issue basically as to the point where new entrants, potential new entrants, they get the licence but not funding approval because they don't have experience in running hospital businesses. Clearly Netcare is, okay, the one question that Gauteng said they don't have an answer to, the question was, how then does it happen that licence eventually ends up with a big established player like yourselves? They weren’t very sure how it works, so I just want to find out if there’s any light you can shed there.

MS DA COSTA Thanks for the question, Dr Bhengu. A lot of these licences and the
process in building, I know Pinehaven took us about ten years to actually build from start to finish, so I'm lacking the knowledge on how the licence was issued, who it was issued to, and how ...

**DR BHENGU** No, it wasn’t a specific ...

**MS DA COSTA** A specific issue.

**DR BHENGU** I'm just saying, let’s say it’s someone who really got a licence but they can't really raise the funding and then suddenly they go into partnership with ...

**MS DA COSTA** Sorry, I thought you were perhaps referring to the three hospitals that we have build in the last three years, because that’s really the only metric I would think of. So, yes, it is true that we get approached on occasion by players and my sense is that it’s not so much the funding, it could be the funding, I mean, it’s a huge financial risk to build a hospital, but it’s also just the lack of expertise. I mean, licences have been issued to a lot of parties that perhaps don't have the experience in running hospitals, and it’s possible that they go from one provider to another to try and see if they can get that skill on board. In general, other than the three facilities we've built over the last three years, I don't think there’s anything more that I could add to this topic. I don't know if you have anything.
**MR NORTON**  Dr Bhengu, I think there are instances where licences are granted to particular parties, and as Melanie has indicated, I think sometimes because of a lack of financing or sometimes because of a lack of skills. They do partner with one of the established hospital groups in rolling out that licence and rolling a new hospital at that particular site. So I think there are instances where that does happen. So I think there are cases of that kind. My understanding, certainly about the Gauteng Department of Health, and I again stand to be corrected, but I think from a policy point of view, have indicated that they’re not in favour of transfer of licences. So you can't apply and then sell off your licence to somebody else. I think generally they want to ensure that people who get given a licence ultimately maintain that licence. It is my understanding, but again, that’s second hand information.

**DR BHENGU**  No, that’s fine. I suppose the issue is that not only does it end there, well at some point you can just interrogate to what extent that support is forthcoming, because I would imagine you want that to be sustainable if people are to come in as new entrants and stay, but that’s fine. Regarding ...

**ADV UNTERHALTER**  I should perhaps just mention, if it’s helpful, that there have been certain competition complications from such partnerships involving joint tariff negotiations where there is a partnership arrangement, and there’s one instance where
that has been prohibited as a practise. So there are certain entailments of these partnerships that have competition implications that have been condemned, as it were, and that gives rise to some problems, because of course some of these partnerships are the only mechanism for certain sorts of entry.

5 **JUSTICE NGCOBO** Those sort of cases, though, don't they call into question the process of granting licence? One assumes that if you apply for a licence whatever document you need to set up a hospital, you’d have to satisfy those who have the authority to grant you the licence that you not only have the finance to build a hospital but also the skills to operate it. Isn't that the criteria?

10 **MR NORTON** Chair, that’s a good question you raise. I must be honest, I'm not familiar with the licensing criteria, so I wouldn’t be able to give you an informed response on that. I understand your question and hear where you’re coming from, but I'm afraid we would probably have to come back to you on that. I don't have that information to hand.

15 **DR BHENGU** We've heard how medical malpractice is becoming a big cost issue from the professional side. You work with professionals all the time and I would imagine that hospitals as well are exposed to medical malpractice issues. What is the impact, from your perspective, of medical malpractice regarding provision of services?
We’re hearing stories of obstetrics progressively stopping obstetrics practise and sticking to gynaecology only, just one example. What is the impact regarding how you relate to the doctors, because clearly if someone, if there is litigation coming, one can see where your interests get tied up, because it’s the doctor treating at your place? As well, is the impact as significant regarding your profitability or even your pricing for services?

**MS DA COSTA** So on the first point as to what is the impact on Netcare directly in terms of medical malpractice, we just recently looked at the stats and in fact it’s really small in the grander scheme of things. From a patient day perspective it’s really small numbers. Just looking at the team to see if you can guide me, it’s like less than a percent of patient days or something, it was really tiny. It certainly is an issue for obstetric doctors operating in our facilities. They have been asking us for data and we've been trying to see how we engage with various parties, to see how we give them some support on this. I don't know if Dena wants to add anything. In general, for hospitals, not so much of an issue. Absolutely for doctors.

**MS VAN DER BERGH** Just on the hospital perspective, in terms of our own insurers, in terms of our own process, we've had to provide a lot more data to them around risk management, around the kinds of things we monitor in order to persuade them to
minimise the insurance requirements that they would have for us and so I would say that over the last two to three years we've had to do a lot more work with our own insurers to make sure that we can demonstrate risk management around those risks, and that’s much more than we've had to do ten years ago in this process.

DR BHENGU  I think lastly I suspect this one is for Barry, regarding the interventions that are outstanding, regulatory interventions that are outstanding, is there, in your view, a preferred order of introducing this, if there were to be support for the additional ones to come in?

MR CHILDS  Thank you, Dr Bhengu. The short answer is there has been some work done on an optimal pathway, if that indeed is the reform pathway that's going to be followed. I think the point I made is that we no longer are on that pathway. If we get back on that pathway then there is a very good paper by Professor Heather McCloud and Peter Grobelaar, and I wouldn’t presume to know, to have a different view to them, and they spoke quite in detail about the order in which some of those reforms would be panned out. I can't recall off the top of my head precisely what that order was, and what the consequences of not doing it. I can send you a reference to the paper, if you like.
DR BHENGU  Thank you. I would like to see that because, for example, the one direct question I would ask is, would you genuinely believe that the environment that we’re talking about, with all its faults, that have been quite adequately heard over the past three days is ready for mandatory membership, for example?

MR CHILDS  Mandatory membership solves one particular aspect, I think, it doesn't necessarily solve any other problems that may or may not be in the system, but with regards to anti selection in and out of the system, mandatory membership would solve that problem. Some kind of risk equalisation or standardisation plus additional income cross subsidisation would help stabilise the risk pools within the environment.

DR BHENGU  I think that was the point, that what is the order, because maybe that would be right solve it but I would like to believe at a particular time it would be, it might even worsen the situation if it’s not brought in at the right time, but I'm sure we’d like to see the study you’re referring to. I think, Judge, that’s it for me. Thank you.

JUSTICE NGCOBO  Doctors have rooms at your facility, do they have a say on who else may be granted admitting rights?

MS VAN DER BERGH  We use the physician advisory board structure to give, they
give input to that process in the physician advisory board structure, yes.

**JUSTICE NGCOBO** Based on what they say, can you refuse granting admitting rights?

**MS VAN DER BERGH** If they gave us good reasons, data, you know, we would obviously make sure that we listen to that data. So I think, just a personal view of not wanting it, obviously we hear and we get input to that, and then together with the management, we’ll make a decision around that process, but if there’s [indistinct] reasons we would consider those reasons and if we didn’t agree with those we would also take that, we would work that ourselves and make a decision.

**JUSTICE NGCOBO** The final decision, of course, is yours, right?

**MS VAN DER BERGH** Yes.

**JUSTICE NGCOBO** You don't feel that if you don't listen to the other specialists they might walk out?

**MS VAN DER BERGH** It’s not our experience that they do that, I think, and it’s, so I don't, I think it’s, theoretically, you know, one could say that, but that’s not our experience.
JUSTICE NGCOBO  Yes. Mr Norton, much has been said concerning the supply of information to the public, how you deal with that. I don't know whether you have done this before, but there are provisions of the National Healthcare Act, I think it’s section 74, if you read that with section 91 (u) (v) I think it is, yes, with (u), section 91 which empowers the Minister to make regulations. Are you aware of those provisions?

MR NORTON  The 91 (u) I am familiar with, Chair, the 74 I'm not, to be honest.

JUSTICE NGCOBO  Would that be, I mean, subject to the methodology that would be utilised in gathering that information, would this be acceptable to hospital as the basis for collecting the information and publishing it?

MR NORTON  Chair, to be honest with you, I think we’d need to think about that quite carefully and come back to you with a formal response. I feel a bit constrained, off the cuff, to give you an answer now. I need to chat and discuss it more fully with the Netcare people, but I think what we have said, Chair, and I think we make this sort of categorical, Netcare has got no difficulty with sharing information, the clinical data information, and I think it was part of a transparent process across the board. I think we’d have absolutely no difficulty with that, and certainly a similar position that was taken up in the UK, I think we’d be absolutely supportive of that. So if it’s in that type
of arena I think there’d be no issue but I think I would need to discuss it more fully with Netcare people and come back to you with a more detailed response.

**JUSTICE NGCOBO** Because no the face of it, it seems to contemplate that the information so gathered which would relate to matters such as health financing, the pricing of health services, business practices within and involving health establishment, health agencies, health workers and healthcare providers, but also contemplates that not all the information so gathered may be published, but some of it may be published in the public interest. What about the next, what about (v), which deals with the reference list, the reference price list?

**MR NORTON** Yes, Chair. I think you’re familiar with there have been previous attempts around the reference price list, I think that ...

**JUSTICE NGCOBO** That was struck down, though. The problem there was, was it not a procedural one?

**MR NORTON** Chair, I think there were a variety of issues, if I recall from the judgement, I think one of which was a delegation issue, that there was a question about whether there’d been a proper delegation by the Minister, but I think there were also a variety of substantive issues which related ...
JUSTICE NGCOBO  Is that the 2010 decision?

MR NORTON  Correct, Chair. I think, to be honest with you, Chair, I think that is likely to be a much more controversial issue and something that we would need to respond to in more detail.

JUSTICE NGCOBO  Mr Unterhalter, are you familiar with that decision?

ADV UNTERHALTER  Yes, I am somewhat, Chair, and I think you’re correct, that ultimately the matter went off on a [indistinct] 2.19.14 procedure.

JUSTICE NGCOBO  [indistinct]. Yes.

MR NORTON  I think they were challenges of substance, they just didn’t need to be determined, as I recall.

JUSTICE NGCOBO  Which therefore means that Mr Norton is right, it’s still a matter which is likely to go back to court.

ADV UNTERHALTER  I think it could do.

JUSTICE NGCOBO  Yes. Okay. Assuming it would not go to court, this kind of provision, what would be your comment on this provision?
MR NORTON  Chair, I think in principle, from what I understand, and again I would need to discuss this much more fully with the Netcare people before I think we came back to you with an informed response, but I think reference pricing, we think is difficult, I think it suffers from some of the same problems that I identified in that slide dealing with price regulation, and therefore, Chair, I think we would say that it’s not a preferred outcome, to be honest, barring a very detailed, substantive type of analysis where everyone sort of was agreed on methodologies and things like that, but, Chair, to be honest with you, I think to give you a proper, comprehensive response, we should probably come back to you on that one.

JUSTICE NGCOBO  From what we've heard this week from the hospital groups, they're all eager to publish the information, but the real issue is the format and how to collate that and how to assess the quality, and perhaps that may be the opportunity to look at this particular provision, wherever regulations are there, just to see whether there’ll be an acceptable methodology.

MR NORTON  Thank you, Chair, we’ll certainly consider that and come back to you.

JUSTICE NGCOBO  It’s quite interesting to look at what appeared to be a mobile clinic. Is it a mobile clinic, the NHN, the one that you use in the UK?
MS DA COSTA  Yes, Chair. That project has come to completion but those were executed through mobile clinics.

JUSTICE NGCOBO  And the one that you had here, you gave that to the Free State.

MS DA COSTA  The mammography breast screening clinic, I guess, for lack of a better a term, and that was donated to, I think it’s the Gauteng province.

JUSTICE NGCOBO  As a matter of interest, have you considered having the mobile clinic going to the rural areas?

MS DA COSTA  Chair, that is exactly what that clinic was about. That is what this initiative was about.

JUSTICE NGCOBO  Is it still continuing?

MS DA COSTA  Chair, it was quite an arduous process in order to get one, the registration of the mammographer, and then two, as a function of not getting the registration of the mammographer, we weren’t able to get the radiation licence from the Department of Health, so after several years of attempting, we eventually donated the unit to the provincial Department of Health.
JUSTICE NGCOBO  What is the attitude of Netcare towards day clinic?

MS DA COSTA  Chair, we have some day clinics within our business. The hospital business tends to be pretty small. We have got 13 day clinics within our primary care unit, so it is something that we continue to invest in. In general, what we do find is they run on very low occupancy. We've had these for many years. The Medicross pricing is thoroughly competitive, I would say if not the most competitive in the market. So I don't know why the model hasn’t really been working to date. We don't know if it’s a function of just the shortage of doctors and doctors commuting from location to the other location, but we do see a place for day clinics within the model. Within our acute business alone we have a significant amount of day care surgery, but standalone day clinic model, one, we are investing in it, but, two, I can confirm that those facilities tend to run on low occupancy.

JUSTICE NGCOBO  That brings us to the end of your presentation, with a sigh of relief from MR NORTON.

MR NORTON  Thank you very much, Chair for your patience and that of the panel. I know it’s been a long two weeks and thank you for your time in affording us the opportunity to speak to you today.
MS DA COSTA And on behalf of Netcare, I’d like to just say the same. Thank you, Chair, thank you panel members, and have a superb weekend.

JUSTICE NGCOBO Yes, also I think on behalf of the panel I do want to thank you for coming to share with us how Netcare operates its business. In particular thank you for your generosity in your willingness to come on a Friday when in fact you were scheduled to come on a Thursday. Thank you so much.

MS DA COSTA Absolute pleasure. Thank you.

JUSTICE NGCOBO Thank you. Thank you, we’ll meet again. Yes, thank you.
Session 3

JUSTICE NGCOBO Good afternoon, ladies and gentleman. I think we should begin to start. I know that we are running out of time. Good afternoon, Minister, and your other panel members. Thank you for your patience. I know that you were supposed to be here yesterday but out of your generosity you were prepared to come today, so as to make sure that at least we listened to your presentation. Perhaps if the Minister could indicate to us how he proposes to manage his presentation and who’s going to be the main presenter and who else is going to assist the Minister.

MINISTER MOTSOALEDI Thank you very much, Chief Justice, and members of the panel. Thank you very much for giving me this opportunity. True, it has been a long time that we've been waiting for this opportunity, also to have our say in what’s going on. With me is the Director-General of the Department of Health, Precious Matsoso, on my right, and on my left is Dr Anban Pillay, he’s the Deputy Director-General for Health Regulation and Compliance, we have got our legal advisor, Advocate Vincent Maleka, SC, next to the DG, we have got Vishal Brijlal, who is a health economist in the Department, and we have got a cast of all other supportive members of the team who will introduce themselves when they speak or help us to
answer.

**JUSTICE NGCOBO** Yes, very well, thank you. I think it would be helpful just for the purpose of the record that whenever a member of your panel speaks, if he or she could begin by just placing his or her name on the record. Thank you.

**MINISTER MOTSOALEDI** Okay.

**JUSTICE NGCOBO** When we are ready, we are ready for you.

**MINISTER MOTSOALEDI** It shall be so, Chief Justice. As you could see from the overview there, we will start with guiding principles and vision and the evolution of the private health sector, the history of regulation and the history of tariff setting. Those will be provided by the Deputy Director-General of Health Regulation and Compliance, Dr Anban Pillay, and the biggest part of the presentation, I will do it personally, but before I complete, I would like to give the opportunity to the Director-General to take the Commission through the various regulatory issues pertaining to the National Health Act, because there’ve been quite a number of questions asked throughout this Commission about that issue. I just thought the time has come for the Director-General to clarify that.

**JUSTICE NGCOBO** Yes, thank you.
MINISTER MOTSOALEDI  Yes, but also, I did not have this on my presentation, I’ll also like to add towards the end of the effects of private market on the public sector, towards the end of that, I would like to add the issues of the PPP to clarify them, particularly, particularly the Lesotho PPP, which has been mentioned as a model that we need to emulate. I was not going to present it, Chief Justice, if it was not the for the fact that we are being told here that we are missing something which is great, by not accepting the Netcare PPP in Lesotho. I would like to come and mention that. A question was also asked yesterday of Mediclinic about the issues of transformation and the number of black doctors within their midst, and one of the areas they quoted as their best performance was Limpopo, which happened to be my home province, I would like to touch on that because I’m of a completely different opinion. Then from there we’ll come to issues of overview and solutions of what we think the solutions are.

Our guiding principles, basically, because we want tell the Commission that our presentation here is not in a vacuum. There are certain principles we hold very dearly, which guides us, which are actually determining the path that you want to take or which we want the country to take, it’s not something that is happening at random. We are saying so because we have noticed, particularly with the presentation from the private hospitals, especially the Big Three, that our definition of health and theirs completely differs, we start from different starting points as to exactly what health is all
about, and I think if that is not understood perhaps, one, that’s why perhaps maybe I'm starting to understand, because I’ve been accused many times of fighting the private healthcare sector, when actually I was not doing so, and I want to put it on record, I've got no war with the private health sector. There’ve been some collegial talk that part of NHI is to kill the private health sector. I want to put it on record that there is no plan to do something like that, there is no plan to kill or abolish the private healthcare sector, it’s not in any one of our policies, it’s not in any secret corner, we've never discussed such an issue anywhere, I want to put that on record, but I also want to put on record that I now realise that maybe that stems from the fact that our basic understanding of a definition of health is completely different, to an extent to where they allocate different meanings to what my role is within the whole healthcare sector, as I was sitting here and listening.

Firstly, we take our definition of health from the preamble of the constitution of the World Health Organisation, that described health, not just the absence of disease or infirmity, but the state of good physical, mental, and social wellbeing, and that enjoyment of the highest attainable standard of health is a fundamental human right, without distinction to race, without distinction to religion, to political belief, economic or social condition, and that health of all people is a fundamental to the attainment of peace and security, and it’s dependant upon the fullest cooperation of all individuals
and the state, cooperation of all individuals and the state. This was adopted between the 19\textsuperscript{th} and 22\textsuperscript{nd} of July 1946 in New York. It’s a very, very important guiding principle. As I was listening here, it looks like this principle is completely absent from some, especially the issue of the health for all the people, all, the word, all. I want you to note, Chief Justice, that the word, all, is going to appear quite a lot in my presentation. This is the first all. I will show you where the second all is, where all the people, because as I listen to the other presentation, especially from the private hospital sector, they seem to be believing that the world consists of those 16\% of the population, they are able to take care of. The other 84\% does not seem to be existing. I don't know where we are going to throw them to, because they are very much citizens of this country. So I want you to underline that, that constitution of the World Health Organisation is talking about all the people, and it’s emphasising that the distinction of race, religion, political believe, economic or social condition should not count.

From there, the Alma-Ata Declaration, the World Health Organisation called a conference at the small town of Alma-Ata, the Alma-Ata was in the former Soviet Union before the dissolution of Soviet Union. If I'm not mistaken, it’s in a state called Kazakhstan now, there was a World Health Organisation conference on primary healthcare, which is just commonly known in health as the Alma-Ata Declaration, that is the declaration they came up with. The first declaration was to emphasise the
definition of health, the second one, which I think is very important, especially for this hearing, is that they said, which you call declaration two, the existing gross inequality in the health status of people, particularly between developed and developing countries, as well as within countries, themselves, is politically, socially, and economically unacceptable, and is therefore of common concern to all the countries. This is the second all, as I promised that there’ll be all in most of the presentation. I want to emphasise the fact that as far back as 1978, it was already being apparent that there is gross inequality of health status of the people of the world between developed and developing countries, but even within countries, within borders of the same country, which matter is very much applicable within the Republic of South Africa, they said, whether you look at it politically, whether you look at it socially or economically, it’s completely unacceptable, and it concerns us all, and this is one of the issues that we are looking at very closely.

Then the concept of universal health coverage, the goal of universal coverage is that all people, that I my third all, all people who obtain the health services they need without suffering financial hardship when paying for them, that’s how a type of healthcare system, where all people, when they need health services, they must not suffer financial hardship, as is the case with the majority of people in our country.
The other consideration, very serious consideration, I was happy to hear it being quoted this morning by the legal advisor of Netcare, but I still wanted to know in which direction it was being quoted, I couldn’t get what’s the direction, the fact that we have got a constitution in the Republic of South Africa and section 27 of the Constitution provide that everyone, that will be my fourth all, because I’ll argue that everyone means all, everyone has a right to have access to healthcare services, including reproductive healthcare, and the state must take reasonable legislative and other measures within its available resource to achieve the progressive realisation of each of these rights, and I want to argue that in our understanding, reasonable legislative and other measures [my] include regulation, not only regulation, it might have to include it. If we have to take those steps that these rights must be realised.

Third one, very much abused most of the time, if we get time we might give you a few examples for its abuse, subsection 3 of section 27 of the Constitution, noone may be refused emergency medical treatment. That I very greatly abused and we are trying to put up steps to bring an end to it. We must confess, as government, that we have not taken action most of the time about that serious transgression of the Constitution, but we want to put it on record that there’s been quite a number of transgression in as far as subsection 3 of section 27 of the Constitution is clear, and we want to state that here, our understanding is that as a state, as a Minister of Health, I've got an obligation, it’s
not something that I just have to choose or I can decide to choose or ignore, it’s an
obligation on me to make sure that this right to health is realised, and I must do
everything in my power to make sure of that realisation.

From there, another guiding principle is the National Health Act, Act number 61 of
2003, the Director-General is going to go through that Act because one of the
weaknesses which we have, as she will say, are the issues of regulations. She will take
the committee through the Act as to what has been happening, but our last bullet point
there, additionally and especially say that it encompasses both public and private
providers of health. As I was listening to presentations here, and in many other forums,
there are people who believe I’m a Minister of Public Hospitals, not even of health, but
of public hospitals and clinics, and confine my job there. That’s why, when I do other
duties, they believe it’s encroachment or it’s interference within something that is not
my work. I want the committee to know that we regard the National Health Act as
binding to both the public and private providers of health.

Then comes the National Development Plan. We never had a plan in prior year, Chief
Justice, but we do have a plan now which has been adopted in by Parliament, the
National Development Plan. It gives us guidance on what Health needs to do until
2030, because it’s also called Vision 2030. I won’t mention the other things, but it
starts by saying, our life expectancy must be seventy years in the whole country. You
cannot achieve that if you don't work and regulate both public and private providers of
health, but the part I want to emphasise, it says by 2030, there must have been a
significant shift in equity, efficiency, effectiveness and quality of healthcare provision,
and that universal health coverage should be available, and universal health coverage,
as you know, that’s what we call NHI. So it is an imperative on the National
Development Plan, and many people in the country said the government must move
very fast to implement the National Development Plan. We so agree and want to state
that in all our plans in the Department of Health, we’re not going to deviate away from
the National Development Plan, we are going to put up all the plans within the
Department in such a way that they are aligned with the National Development Plan.

Then we’re also guided by what happened in New York at the United Nations when the
seventeen sustainable development goals were adopted. Goal number three is a goal
for health, and it says, target 3.8 on goal number three says, we need to achieve
universal health coverage, including financial risk protection, access to good quality
essential healthcare service, and access to safe, effective, quality and affordable
essential medicine and vaccines for all. This will be my fifth all in the presentation, but
it says we need to do that, and it was adopted on the 25th of September 2015 at United
Nations.
We want to state that we believe this shows, Chief Justice, that health is not just any other ordinary commodity of trade, it’s completely different from other commodities of trade.

Now, the current context, prior to 1994, I'm sure everybody’s aware that Health was fragmented into fourteen different departments along racial lines. There were four departments for four race groups, but there were also a department for each of the Bantu stands and so it was fragmentation at that level. Remember that these departments were not just departments, they had ministers, they had many people who were regarded as ministers, as director-generals, they had different policies, but saving population groups within the borders of the same country, and I just want that to be conceded, because it is still very much part of the problems we are solving, even today, after twenty years of democracy, which many people, of course, conveniently forget. 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, and so when the Constitution came in to abolish this system, we were dreaming of a seamless healthcare system, but inadvertently or for reasons that maybe might emerge from this Commission, when we woke up twenty years later we have got a two-tier healthcare system, one public and one private.
This is very unfortunate because it’s not established by any constitutional principle, it just evolved on its own, but you also want to emphasise that the private sector, when it developed, there was no clearly defined or designated policy, and it’s part of the problems, that I heard the Commission asking of many people. You see, we are busy with the National Health Insurance, we have produced a white paper which is being scrutinised left, right and centre by all sections of the population, and from which we are going to have an act, but if you look at the evolution of the private sector, the laws and the policies ran behind what has already been established. What I'm trying to say, and I'm not putting any blame on anybody, I'm just giving history, that many of the, for instance, when I was a medical student some thirty years ago we didn’t have as many private hospitals as we had, our tertiary hospitals were the best that healthcare could provide. We cannot forget the fact that the first heart transplant ever in the country has been done on a public hospital, right here in Cape Town at Grooteschuur Hospital. We’re very, very far from that situation today because a new system has emerged alongside the system that used to exist, but that system, when it emerged, there were no clear cut policies, principles or laws. Some of the laws came after and that’s one of the problems that actually exacerbated our situation, but this scenario of having two-tier systems has produced very clear and clear in inequalities. We divided the country into quintiles, that means quintiles according to income groups. This was a study done,
conducted by Professor Di McIntyre, and Ataguba, Professor Di McIntyre is the Head of Health Economics at University of Cape Town, that they divided the population into five quintiles, that means the richest twenty percent, the second richest twenty percent, the middle twenty percent, then the second poorest twenty percent, and the first or the top poorest twenty percent of the population. What we are trying to show there is that on the screen, the issue, look on the right at the bottom, that blue colour there, represents the percentage of the needs of share of need of the poorest twenty percent of the population, that means the poorest quintile. That blue colour there represents their health needs, but when you move to the left you look at their benefits, much, much smaller than their needs, but that's what they get from the healthcare system, but when you move to the top, that red colour, I don't know whether it’s red or pink, it appears pink on the screen, on the paper I'm having it appear as red, right at the top there you see the health needs of the richest twenty percent of the population, right there on top, very small health needs, but when you look at the left, you’ll find the benefits that they get, much bigger than their needs. So we are running a healthcare system whereby the poorest do not get what they need in terms of health, the richest get much, much more than what they ever need, which means there is over servicing of the rich, but a gross under servicing of the poor, and that is not the healthcare system that we could allow ourselves to go on with.
Now, the issue of health expenditure. The World Health Organisation recommends that countries spend five percent of their health, they’re not saying we should spend five percent, they’re said at least if you spend five percent of your Gross Domestic Product on health, you ought to be have good health outcomes. That means the status of health within that country, within the population of that country ought to be reasonable because you’re putting resources, at least five percent of your GDP on your health. South Africa is already at 8.5 of the GDP which means we’re supposed to be counted among the countries whose health outcomes are the best in the world, but that is not so. It is not so because of the manner in which the money is divided, because 4.4% of that GDP on health goes only to sixteen percent of the population, that’s about eight million people, but 4.1%, the lesser amount of that GDP has to serve eighty-four percent of the population. There is no measure or indication of gross inequality than what you see on the screen there. It does not exist anywhere in the world that we can explain gross inequality more than the manner in which it is shown on the screen, and that is another problem that we need to solve, that we are faced with.

Now, are we the only country in the world that are faced with health challenges? By all means, no. The Director-General of the World Health Organisation, Dr Margaret Chan, at the 65th World Health Assembly in Geneva, when she had just been elected for the second five year term of office, she outlined what she called seven structural
problems of health faced by health systems around the world, that this rise in healthcare cost, yet poor access to essential medicines, especially affordable generic medicine, that there is emphasis on cure that leaves prevention by the wayside, and I've heard a lot of speech since yesterday, healthcare system based on a curative model, that leaves prevention by the wayside, and she said, we also have problems of costly private healthcare for the privileged few, but second rate care for everybody else. I want the Commission to note that she’s not complaining about private healthcare for the privileged few, but costly, the word, costly, it is costly, but it’s for the privileged few, and I’ve already mentioned the numbers, then for everybody else it’s second rate care. Then she said there’s a grossly inadequate number of staff or the wrong mix of staff, and the weak or inappropriate information system.

Number six, Chief Justice, I need to explain, weak regulatory control. In South Africa that is very clear and a report by Judge Jody Kollapen, when he wrote that report before he became a judge, when he was the chairperson of the Human Right Commission, he was doing public inquiries about access to section 27 of the Constitution, and access to health, in terms of section 27 of the Constitution. He came across this issue and he wrote in the report then warned us that there is weak regulatory control here, because he pointed out, in private healthcare, whereas you have got two arms, the funders and providers, we are regulating only the funders. We do have a
statutory body called the Council of Medical Schemes that is regulating the providers. There is absolutely no clear cut mechanism to, sorry, the Council of Medical Aid Scheme is providing the funders, the providers is a big struggle to regulate them, and the DG is going to be maybe outlining at the same time, Dr Pillay. Our struggles in regulation the provider of healthcare services, when people are claiming that there’s no regulation, they are not lying, but it’s not without trying. There have been quite a number of obstacles put on the path, not that we have given up, but we just want to demonstrate that we are very much aware that we have got part of healthcare system that is badly regulated, and Dr Margaret Chan was just flagging this point for quite a number of countries around the world.

Number seven, she says we have got schemes for financing care that punish the poor. I have seen a lot in the media accusing me that the Minister of Health is saying medical aid schemes are a punishment to the poor, he hates them. It’s not me who said so, it’s the Director-General of the World Health Organisation, I just want to put it on record, and I was quoting her and I think I’ll keep on quoting her again and again and again because I think she was telling the truth, and that is clearly defined in South Africa.

Now, the problem that we are having in South Africa is that while countries are choosing which one of the seven pertains to them, all seven of what you see on the
screen applies in South Africa, all those seven structural problems exist within the healthcare system in South Africa. Dr Margaret Chan went on to say, the solution to these problems is universal health coverage, and she said universal health coverage is the single most powerful concept that public health has to offer, and she said it’s a powerful equaliser and the ultimate expression of fairness. It’s an equaliser, it’s a social equaliser between the rich and the poor and it’s an ultimate expression of fairness, because we also want to state that our Constitution is not only based on legality, it’s also based on the principles of fairness and principles of justice.

I was just emphasising there that South Africa is unfortunately faced with all these seven problems. According to the National Development Plan, after telling us what we need to do until the year 2030, the National Development Plan said, ultimately there are two problems that the healthcare system in South Africa must solve, two. The first one, the quality of services in the public health system must be improved, and I want to accept here that we do have very big problems of quality of services in the public healthcare system. There are people who believe we are trying to hide this fact. We cannot because we need to solve it. It’s a very, very big problem bedevilling the healthcare system. The National Development Plan said, that problem ought to be solved and we are agreeing with them and we are putting measures in place to solve, but the second, they said we need to deal with the relative cost of private healthcare
and this must be reduced. I know there have been a lot of questions about whether private healthcare is expensive and maybe people believe this Commission must determine that, but I just want to put it on record that the twenty-five eminent commissioners who were in the National Development Plan have already reached that conclusion and they put it as one of the problems that this country must solve. In other words, I don’t know whether we are here to determine how it happened or whether we’re to determine whether it is so, but just to put on record that if we are trying to determine that it is indeed so, we must know already that the National Development Plan has already concluded that it is so, and it must be solved. So we have got two main problems that the country is faced with and we must solve them simultaneously.

The issue of evolution of private healthcare, we want to argue that in the evolution of private healthcare, private hospitals were not always the highest expenditure item for medical aid schemes, and I’m sure when medical aid schemes here presented, they showed what is their highest expenditure item. We want to argue. If you go to as far back as 1974, you’ll notice that the top blue graph there is expenditure on practitioners, what was more expensive at that time was practitioners, but as you can see, it kept on rising, rising, but right until 1998 the biggest expenditure in private healthcare were practitioners, and they were followed by medicines, that means the pharmaceutical sector was the second most expensive, and only then the third, where the hospital
groups, the private hospitals, and at the bottom is others, other services. It has always been like that. We want to argue that there was a sudden change, even when you move to practitioners, themselves, at the top there, medical specialist followed by general practitioners, then dental practitioners, it has always been like that. We want to argue that there was a sudden change and that sudden change, if we look at this graph, that is from 1997 to 2007, that sudden change happened round about 1998, 1999. The top graph there in broken lines indicate the total premiums that were collected by medical aid schemes, the total amount of money in the forms of premiums that were collected by medical aid schemes from members who have joined. As you can see, if you look at 1997 up to ’98, it was more or less moving in a flat line, but from ’98 it just started turning sharply upwards, but it also shows then that the amount of money going to the private hospital groups is more or less shadowing the total amount of money that was collected, and the other costs are following quite low, but it shows that somewhere, somewhere around 1998 something happened in this country. That needs to be followed. I am mentioning this because I want to give over to Dr Anban Pillay to determined what, in our opinion, what are the events or the factors that took place in 1998 that changed our situation so much, because that’s our argument, that lots of things started changing at that time. There will be other periods where we show when changes happen, but we believe somewhere around 1998, 1997, something happened
around the country that brought us to the problem here where we are. It just did not evolve automatically, as many people would like us to believe. Dr Pillay.

**DR PILLAY** Thank you, Minister, thank you panel members.

I think the key question is, is this evolution or coincidence as to why did prices rise so significantly over the period.

As you saw in the history, that historically these prices were not high, they started developing over a period of time. We argue, firstly, that the market has been concentrated and it started concentrating itself around 1996 to 1998 and that concentration continued. As you can see from the graph the independent group which is reflected in green started reducing in size and consequently the graph for, the bands for the other three large hospital groups started expanding, which leads to this concentration.

What we also see is that the private hospital real cost strength, if you look at the medical scheme beneficiary data, suggests that from about 1998 we started seeing these increases in costs for medical scheme members and this data comes out of the Council for Medical Schemes. So this is the second piece of evidence that suggests that certainly market concentration seems to point towards these increases in costs.
Thirdly, this is some work that was done at the Council for Medical Schemes around growth in return on investments, and just to share with you, the blue bars refer to the return on investment of private hospitals, the red bars reflect the cost of debt, and what you notice is that from about 1998 that the return on investment exceeded significantly the cost of debt and that has been continuing over time, which means that the return on investment for investors is much higher than the cost of debt for these companies if they had to use funds from the open market to be able to access the capital investments.

Additionally, if we look at the returns, this work was done by Do Hospital Mergers Lead to Healthy Profit, it’s a paper that was published, I think it’s also available to the panel, do returns on private hospitals, how do they compare with global hospitals, and you see over the period of time the global hospitals are reflected in the green and our three large hospital groups are the orange, the blue and the red bar, and over time you see that our private hospital groups have been faring very well relative to the global hospital groups around return on investment, which again suggests that we’re performing very well, and the question is, is this related to the market concentration as well.

Additional issue that we must talk about is the listing of these three hospital groups on the stock exchange. These three large hospital groups, as you are aware, are listed on
the stock exchange, and we know that companies that are listed on the stock exchange must consistently produce profits that are in line with the investor expectation. These principles often can come in conflict with the ethical responsibilities of service delivery, particularly in healthcare, where the health of patients are primary, irrespective of their ability to pay.

I don't want to suggest that listing on the stock exchange is necessarily a bad thing, there are examples of companies that are listed on the stock exchange that have been able to make healthcare accessible and here I reflect particularly on the pharmaceutical industry. There are a few pharmaceutical manufacturers in South Africa that are listed on the stock exchange. They’re subjected to price regulation and regulation of the quality of their products, and the reduction in the prices of the products have not resulted in their returns being reduced significantly, however it does suggest that investor expectation needs to be managed in this context, particularly when we’re looking at healthcare, because the primary objective here is the patient.

Additionally, if we look at the total hospital cost and here we took the first example, which is bypass surgery, looked at data from the International Federation of Health plans, and this was in our submission, but in addition to looking at it from a household income perspective, we also looked at it from the GDP PPP perspective, which is
trying to compare, are based on purchasing power parity, which attempts to equalise across countries in comparing costs, and this is the actual price of these services, and what you notice in the case of bypass surgery, is South Africa is only second to the United States and we know in the US currently they’re busy discussing how they can make healthcare more accessible. Significant differences between South Africa and all of the other countries.

If we take another example which is angioplasty, same picture, South Africa significantly higher relative to the other countries, our only peer is the United States. If you look at hip replacement, a similar pictures, South Africa second to the United States, significantly higher than many of the other countries.

So the question is, are these procedures so complex that they become so costly? Is there some interventions that happen in South Africa that don't happen in these other markets that result in these high cost? What about simple procedures? Maybe some of the answers could come from that. One of the simple procedures, for example, may be medical circumcision. The Council for Medical Schemes in 2013 had average claim ratios from the medical schemes, and we used this to do some analysis, and for general practitioners who do a circumcision, they get paid R1,121 but hospitals charge R7,130. The question is, is this really a difference in the medical male circumcision between
GPs and hospitals that there should be such a big difference in the price?

MINISTER MOTSOALEDI  Can you allow me to interject a bit, Chief Justice? This slide, the reason that we went looking for it, I convened a meeting of captains of industry in Gert Sibande district in Mpumalanga, that is around Secunda. My worry was the rate of HIV Aids is very high there, in the forties, and forty percent of the electrical power of the country comes from there, for those who don't know, Eskom obtains forty percent of its power just from that district, that’s where the mines and the power stations were, and one will worry, if you’re a Minister of Health, and you know that, and you see it is this pattern moving like that because one day everybody there will be sick and our power will collapse. So I went to meet captains of industry to ask them, that it’s in their interest and in the interests of their businesses to help. During that meeting the director of Sasol Med, stood up and, because I said provide ARBs, don't wait for the state, for all your employees, please help us with medical male circumcision, the director of Sasol Med medical aid scheme stood up and said, Minister, we agree hundred percent but help us, we could circumcise all the males on these medical schemes, and he said we have got eighty thousand members, but they’re charging us R7,000 in the private hospital, and our people insists on going there because they’ve got medical aid. She then said, we are aware that the American funder, PPSA is paying doctors in this very country R400 to do circumcision, can you
help us on that one. The second thing he raised was, you have just, Minister, introduced the six dose combination of ARBs, you are paying R89 per patient per month but for the same drug we are charged R400 per patient per month, and she said, if you help us on these two issues, then we’ll be able to help you. So I just want to flag that we did not just get these just as figures because then I was shocked, I needed to go and find out what is he talking about. I went to the Council for Medical Schemes and said, show me exactly what this man is talking about, and that’s when they produced that slide and this is a summary of the letter they wrote to me, when they were showing the cost of, average cost of a circumcision in the public hospital, the average cost of a GP, and I'm adding that the cost of what PPSA is paying to individual doctors. Thank you very much. You may continue.

**DR PILLAY** The second area that we wanted to explore is that clearly I think the panel has heard over the weeks that patients generally don't choose hospitals, they choose specialists, and specialists usually then decide as to where the patient is going to stay. So the game has to be that you need to get specialists to admit patients into your hospital because if you don't get specialists to do that you basically have an empty hospital.

So is an interaction between hospitals and specialists that results in these increased
market power for specialists and what we call supplier induced demand, which would include what we would call a medical arms race? A medical arms race is hypothesis that describes whether hospitals spend unnecessarily on cost enhancing technologies in order to attract patients via the specialists referrals.

The example we’re going to use around CT scanners, but I think there can be several others that, if we explored, we could do the same. This analysis was done on the South African diagnostic imaging equipment, it was published in 2015, and it refers to CT scans per million population. On the left you see the number of CT scans per million population, the private sector, in the second bar is the OECD average, and the third is the South African average, and on the right the public sector. You can see the massive difference between the public and the private sector, but I suppose more telling is the fact that the South African private sector has more CT scanners per million population than even the OECD average. The question then becomes, well, you may ask, so what’s the problem, does it really matter? I mean, there’s lots of CT scans and you could go in and use the CT scan whenever you want it, it’s highly available. Remember, these are extremely expensive pieces of equipment and somebody must pay for them. The question is, does this high number of CT scans mean that the costs are high?
So let’s see. If we look at CT scans for the abdomen, again, looking at the data from the International Federation of Health Plans, South Africa is the highest, not surprising because we’ve got much more than the OECD average, even overtaking the US in this case. Let’s look at CT scans for the head, similar picture, but this time the US seems to be ahead of us but everybody else much lower. Let’s look at CT scan of the pelvis, similar picture, second to, US is much lower us in this case. MRI, again, the South Africa is the highest relative to all of the other countries in the comparison.

We then looked at comparisons looking at CT scans relative to gross household income, and there’s this argument, I think the panel’s heard this a few times, that we’re not actually interested in the entire South African population, what the Minister talks about, the all, we just want to take the cream of the cream and we want to deliver services to them. The question is, does the higher level income South African able to afford these CT scans relative to the other markets in terms of gross household income, and what you see is that the red bar relates to the entire gross household income for the entire South African population, the yellow bar is adjusted to only half of that population, so we’re removing the poor, we’re keeping the top end. We’re saying, so what does mean? Does it mean that the top end would be able to afford this? Well the picture doesn’t change very much. We did the same thing for CT scan of the head, you see that South Africa still comes up on top, we did the same thing for CT scan of the
pelvis, in this case the US is slightly higher in terms of the yellow bar but in terms of the red bar you see it’s still South Africa the highest. Then if we do the MRI scan, you see that South Africa now in terms of the yellow bar is just lower than the US but in terms of the entire South African population, South Africa is still the highest.

The other area that we looked at is supplier induced demand and here we looked at circumcision rates, the circumcision rate in the private sector in South Africa, sorry, C sections, seventy-five percent of the C section, the Caesarean sections in South Africa done in the private sector, one of the highest in the world, and the question is, is there something wrong with South African women that seventy percent of them in the private sector must have Caesarean sections? What the graphs shows us is that in 2011, and compares that 2013 data, you see the blue bar refers to the prices of normal deliveries, the red bar refers to the price of Caesarean sections, and what you see is that the average length of stay in the case of the blue bar relates to the normal deliveries and the red bar relates to Caesarean sections. Massive difference between the two, largely because of supplier induced demand in terms of the normal deliveries relative to Caesarean sections. Effectively what this means is that in the private sector the clinician actually decides on your birthday, if you think about it, because that’s actually determined well in advance in terms of when South Africans are going to be born.
Let us look at hip and knee replacements, 2011 to 2013. In the case of appendectomy or repair of hernias, we notice that if we compare the data from 2011 to 2013 there is a green triangle which refers to the increase between 2011 and 2013, and the purple line refers to the increase in membership. What we see is that in the case of appendectomy or the repair of a hernia, that the changes were fairly small, 5.7% and 7.5%, but in the case of hip replacement and knee replacement, these increases were 31.9% and 53.7%. The question is, did something happen in South Africa that between 2011 and 2013 suddenly there were so many hip and knee replacements that we don't know of any epidemiological occurrence that could explain this other than supplier induced demand.

If I can hand over to the Minister.

MINISTER MOTSOALEDI Thank you. Chairperson I just want to deal with the issues of what in our thinking we believe happened to the medical scheme world. We believe what Dr Pillay has just demonstrated is what I will regard as an onslaught on prices, and we believe with this onslaught on prices medical schemes responded, but we believe they responded only to protect themselves, because quite a number of them were collapsing. I didn’t show the slide here but medical schemes are definitely collapsing. We used to have hundred and forty-one of them in 2002, we are left with eighty-three. So they had to protect themselves because they were under onslaught, if I
may say, but unfortunately instead of tackling the source of the onslaught of the source of the high prices, which we regard and we have demonstrated here, is the private hospital sector, especially the big hospital after the market concentration, and to an extent the specialists. Instead of tackling that, we believe the medical aid schemes rather conveniently moved to the weakest link in the chain, and we believe there were two victims of moving to the weakest, whoever is the weakest, we believe the first victim was the general practitioner, those who are providing primary healthcare at the general practice level, we believe they became victims of this war, and the second victim was the patient themselves, and we believe the patient became victims because of information asymmetry, and here I want to say that information asymmetry is not only for people who might not have gone to school, it’s for everybody, even for people who are in the medical profession themselves have been victims of this, including myself, by the way, Chief Justice, I've been a victim of this on several occasions, despite the fact that I believe myself to be having a wealth of information, but the power asymmetry is just like that.

So we believe we need to look at these two victims.

JUSTICE NGCOBO Did you want to share with us, Minister, how that occurred?
MINISTER MOTSOALEDI  Chief Justice, I'm on one of the most expensive medical aid schemes which is Parmed, it’s a medical scheme for members of parliament and judges, yes, it’s one of the most expensive medical aid schemes, I am paying R14,000 per month but my benefits were finished in October, and I've never been admitted to any private hospital, as you will know, I only attend public hospitals but, yes, and the whole family, I can give you a whole list of when my wife was admitted to Steve Biko Academic, when I was admitted, my daughter, and all the family members, we go there for our care, but despite paying this R14,000 my benefits were finished by October and I had to buy, to pay everything cash. It’s one of the issues that we are still going to visit because I suspect Dr Norman Mabasa, on the 17th of February, was trying to show something like that but without maybe mentioning individual people who must have suffered.

The second part where I became a victim. In 2009 I had a four year old son who was in a private hospital, five days later the diagnosis was not made, his temperature was forty degrees, I was very scared because they couldn’t make the diagnosis. So I wanted to transfer that child to Steve Biko Academic Hospital, something that people believe is madness because there’s a general belief that public hospitals know nothing. I wanted to transfer the child there so I called a private ambulance. The distance between that private hospital that was in Magubane where my in-laws are, and Steve
Biko Academic Hospital, I think it’s between thirty and forty kilometres, if I'm not mistaken, and they said they wanted R5,000. Of course I was prepared it, this is my son, then I phoned the ambulance, I think it was Netcare 911, and they asked me lots of information from my ID to income to everything, and I responded, but two hours later the ambulance was not there. I phoned again, they asked me again this information, I provided it.

Two hours later the ambulance was not there, then my levels of fear ratcheted. I phoned again and I was told that, no, we actually don't believe that you’ll be able to pay this R5,000, that’s the answer I was given, that we don't believe you’ll pay this R5,000.

I actually have to fight and get the public ambulance to take this child, I must be fair at this juncture, I phoned the chairperson of Netcare, Mr Jerry Vilakazi, who contact, is it Mr Friedland who is the CEO, yes, I must confess because I must be fair to him, he then told me that all their phones are logged, then he went listen and he came to me, he wrote me a letter and apologised and said he’s also happy that during the whole conversation I never disclosed who I am, because that lady told him that, no, he didn’t tell us he’s the Minister, and of course I was doing that very deliberately, I don’t usually want to throw my name around because I was doing it, not as a minister, I was
doing it as a father whose child is sick, and there are many fathers whose children are sick, and if they have to use their status in order to get into hospital or get services, that will be a very sad day in the country. So he thanked me for no having disclosed my name, despite the fact that I was getting this onslaught.

JUSTICE NGCOBO But you became a victim of your non disclosure.

MINISTER MOTSOALEDI Yes. Now, I said the GPs are victims. The previous graphs at the beginning were showing you that practitioners were the most expensive. The share of GPs in what’s happening within the medical schemes environment has been going down at a very pace. At some stage it was twenty-four percent. As you can see here in 2010 it’s only nine percent, it’s now down to seven. That means out of a total of 87.4 billion which was collected by medical aids in 2010, GPs got only 6.2 billion, regardless of their number, and then it actually shows 2012, 2013 that their share is going down, it’s going down very, very fast, as you can see from there.

There are sometimes claims that there’s an exodus of doctors from this country to UK and that it’s the government that is chasing them away. Many GPs are leaving here, going to the UK because their share is going down very, very fast, there’s a complete onslaught on them because the system we are having no longer respects primary
healthcare practitioners like GPs, and I am not defending them because I was once a GP, Chief Justice, I'm just stating a fact which you can see with figures there.

The onslaught continued on patients. This slide here is an invoice which was given to me. I, a member of the public, who then asked me to blame office names, I'm sorry, because I don't have names there and medical aid numbers. He asked me, but he said please take these to teach people.

I was addressing people in Pretoria City Hall about NHI, and after I spoke and he came to me, he gives this, he said, I'm giving this to teach people. He went to a private hospital, was charged R19,100 and as you can see there the medical aid scheme paid only R5,109, and then R13,990 he had to pay from his own pocket. This is what is called a copayment, he’s paying much more than even what the medical aid scheme is paying. The argument here the medical aid scheme will have is that this service cost is only this but the private hospital cost demands R19,000. So who becomes the victim? It becomes the patient, and that’s why I'm saying patients and GPs became victims here.

Now, this issue of copayments, the World Health Organisation says we should not allow it within the healthcare system. Well, I thought there was in a way desperate attempts of medical schemes to survive. One of the was the issues of PMBs which I
would like to visit later on, but because people did not understand me when they were interviewing me, when the Commission started, about the issue of PMBs, I used the word, *zama zama*, and unfortunately members of the press, and I think if they’re here I need to clarify the issue, they said I said medical aids are *zama zamas* and according to them *zama zamas* are illegal miners, and so they were saying I'm saying medical aids are like illegal miners, I'm still not sure. Many media, about three newspapers reported that it was very confusing.

What I was meaning is, Chief, to me, Zama is a Zulu word for trying, that if you keep on trying something bit by bit but not winning you are doing a *zama zama*, it has nothing to do with miners. I was saying this whole concept of PMBs, we were trying to paper the cracks of a system that is not working, and it didn’t produce results and I would like to visit that later. Those who were in the media who wrote of *zama zama*, of PMBs as illegal miners, please go and correct that. There’s no relationship between the two except that they were using the same meaning, that I'm really trying to make a living.

The other slide shows the other issues that happens in medical aid schemes, Chief Justice. My understanding is this, a lot of money is being pushed towards administration, and I believe it’s not an accident because according to the Medical
Schemes Act, medical schemes are not for profit organisations, are benefit organisation that are not for profit, but I believe administrators do make a profit, and I want to argue that lots of medical schemes do push that money for administration in order to make a profit and that’s what we’re watching here. When you look a the number of the top there, at the top, the red is the amount of money that is paid per patient per month for administration, and as you can see at the far end is GEMS medical aid schemes that is spending very little, for the simple reason that the state is not chasing profit. I don't think it’s because the state is much more efficient, as they always claim, but because we’re not chasing a profit but just money for administration, that’s why we can charge one third than what is really being charged there, and because we believe that is not just an accident.

Another undesirable practise is, we note that members of medical schemes, the total members never increased over the past decade, but as far as you are concerned it remained constant, more or less, but there are brokers within the system. In my little understanding of the business world, brokers are wanted in the insurance industry to recruit people and make them join various insurance companies, that’s why you need brokers, and so once you have got brokers, the number of people who are joining insurance companies must raise.
Now we have got a situation in health where we have got brokers who are working within the medical schemes industry. Before 1998, again, the year 1998 which seems to be a magic year, emerges, before 1998 they were almost non existent, they just increased until by 2006 they had increased by eight hundred percent. I want to put it on record here that we believe the system doesn't need brokers.

All they do every year is to send one percent from medical schemes to another. In other words, this year they ask you to join one medical aid scheme, next year they just look for one sentence there which changed and say this is a better medical scheme, look there, they’ve added this one the previous medical scheme doesn't have, and then you go and join. At every such incident there’s a transaction.

The total amount of money going to them from the healthcare system is R1.5 billion. We think that’s unnecessary, that amount of money should, if we go back to the slide that I've shown about where the money is going to, yes, it accounts, that R11.6 billion, part of that money, that’s administration money and that’s also brokers money, if you look at it, this money is two times, more or less two times that which GPs are getting.

Now, GPs are providing healthcare because this is health, but somebody who is called non health is getting more money than them from healthcare, but is not providing health. That situation is very sick. Can’t be accepted. Part of those who are getting
non health is this administration and this issue of brokers, and we are saying here boldly that we don't think the system needs brokers at all.

We are now coming to regulatory mechanisms.

**DR PILLAY** I think we’ve outlined a number of the challenges, so the question is what have we been doing in trying to address these challenges? I think if we can go through a little bit about the history of regulation, I think it would be very helpful for the panel to get a sense about what we've attempted and what has been the responses so that in understanding where we are now and why we are where we are.

Firstly just to outline what legislation exists in terms of the sector. The first is the Medical Schemes Act, and I think we do lots of presentations on that, the amendment that’s linked to that, there was also the statutory minimum benefits, there was 1995 NHI Committee of Inquiry, the Medical Schemes Act reintroduced prescribed minimum benefits and community rating in 1998, PMBs were introduced in 2000, we also had the single exit price and dispensing fees for medicines in 2004, and in 2010 we had the National Health Reference Price List which was struck down.

First, if I can start a little bit on the PMBs. In trying to protect patients, the Minister of Health and the Council for Medical Schemes established a prescribed minimum
benefit. These PMBs are a set of defined benefits which ensure that all medical
scheme members have access to certain minimum health services, regardless of the
benefit option that they have selected. The aim is to provide people with continuous
care, to improve their health and wellbeing, and to make healthcare more affordable.

However, this has clearly not achieved its desired effect, and I think the panel’s heard a
lot about that. Instead there are serious unintended consequences of bringing in
opportunism from providers, and this opportunism has subsequently raised medical
inflation instead of creating affordability for the members of medical schemes.

The history of medical schemes in 1996, PMBs were brought in, the medical schemes
[car] scheme, which was established in 1997 was responsible for defining and costing
the minimum package of essential hospital care. It’s recommended that primary care,
chronic psychiatric, infectious diseases should be provided by the state and funded
through the tax revenue, and that five hundred and ninety eight diagnostic treatment
pairs are allocated to discretion. Effectiveness and cost considerations in order to
facilitate the prioritisation, these interventions were then ranked according to various
mixes. So the final core package excluded interventions that were considered to be
ineffective, non urgent, non life threatening.

However, I think you’ve heard a number of questions about some of the conditions that
are within that list. The PMBs are not envisaged to be a hospital based service only. They are also provided in the ambulatory care setting and schemes are obliged to pay in full for these services. So 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 prescribed minimum benefits in an out patient setting where this is clinically appropriate.

So what has the impact been of this regulations on expenditure distribution? This is a depiction of the total benefits. Similar to the one the Minister showed us just now, if you look at the green line, reflects the expenditure on private hospitals, and just recapping the graph I showed you earlier you see that private hospitals are not always the biggest expenditure. You see the purple line, which is the medicine expenditure, which was actually a high expenditure item until interventions in terms of generic substitution medicine regulation, etc. and then we see the specialist costs in the red line which has been increasing, and you see a trend between the private hospital costs and specialist costs, which is understandable because they need each other in order for the service to be delivered.

If we go now and just trace back a little bit about why did these things happen and try to understand what’s been happening, if we start with the general practitioners as a
percentage of total benefit, what we see is that when we had the RAMS tariffs being removed we see the general practitioner income decline quite significantly. We then see prescribed minimum benefits being introduced and then there was a little bit of stabilisation, and then the dispensing fees were introduced thereafter and general practitioners became preferred providers in terms of dispensing of medicines, to some extent. Then we had the National Health Reference Price List being removed.

One of the things we could conclude from this graph is that when regulatory interventions were removed, the extent to which GP income declined was quite significant, largely because in order for GPs to be able to compete in the health system, given that their gate keeping role has effectively been removed from the system and specialist consume effectively a greater portion of the health budget, largely because patients bypass GPs, so when there are no tariffs in place clearly the gate keeping role, together with the absence of tariffs results in GPs actually losing a significant amount of the income that they should actually be earning relative to what actually goes to specialists.

In the case of specialists you see a different picture. You see the impact of the regulatory tariffs, you see when tariffs were removed that the specialists income increased quite significantly, PMBs contributed further to that. What’s also interesting
is that when dispensing fees were introduced, these dispensing fees were regulated and those specialist groups that were dispensing then stopped dispensing, but what they then did was transfer the fees that were gained or the income that was gained from dispensing to their actual consultation fees, and then you see those fees increasing, and then finally when the National Health Reference Price List was removed then you see an uncapped environment in which people could charge whatever they like.

Private hospitals, fairly similar picture to that of specialists. As regulation is removed you notice that the expenditure on private hospitals continues to increase. We have market concentration which is another contributor, obviously, to the increases. What we also note is that the single exit price and the dispensing fees, when that was introduced as well, what happened was that hospitals then said they would charge net acquisition price, but what they didn’t tell us was that they then said, we’ll transfer that income to ward and theatre. So what happened was that whatever was lost on medicines was then transferred to ward and theatre fees. So you see those increases continuing. Then when then NHRPL was removed you then see the picture continuing.

**JUSTICE NGCOBO** Before you leave this topic, these slides do not deal with the challenges relating to PMBs which we've heard about over the last couple of weeks.
Are you going to deal with them at some point?

**DR PILLAY** Yes.

**JUSTICE NGCOBO** Okay, very well.

**DR PILLAY** Coming now to the history around tariff setting in terms of what has been our attempts to address this matter, and what has been the response, the dynamics around this. Just a little bit of history. The RAMS, which is the Board of Health Care Funders, as they are known now, had the legislative responsibility of negotiating service tariffs. The regulated maximum prices that providers could bill were equivalent to the reimbursement levels, and this is critical because it’s important that when the tariffs are negotiated that the reimbursement rates for those providers are linked to that and patients are not then faced with a copayment at the point at which their service has been delivered.

In 1994 the process was abolished through the amendments to the Medical Schemes Act and RAMS negotiated guideline prices with provider organisations. Then we had the recommended scale of benefits for medical practitioners and these were aimed to assist medical schemes with embarking on their own price negotiations with providers. The South African Medical Association published the Doctors Billing Manual which
competed effectively with the RAMS reference price list with fees that exceeded the
RAMS guideline prices. Patients then had to pay the difference between the
reimbursed amount and the price charged. This is where the issue of copayments came
to the fore and has been expanding ever since.

At the same time HASA received permission from the competition authorities to
publish a benchmark guide for two fees for medical schemes. SAMA published its last
benchmark guide for fees for medical services in 2003.

In 2004, as you’ve heard, the Competition Commission, and you are aware that there
was a ruling that prohibited any collective negotiation of prices and it ruled that the
centralised tariff schedules were set in a collusive manner with anti-competitive
outcomes. Unfortunately this ruling did not take into consideration the effect of the
practise but only the form, relying on per se prohibition provision, which doesn't
require any justification or the weighing of effects of the conduct in the market.

The consequence of this ruling was that requiring medical schemes and patients had to
negotiate tariffs with individual healthcare providers, bearing in mind that in the
current environment for a patient to be able to negotiate a rate with a provider of
healthcare at the point at which they’re seeking their care is a very difficult
responsibility. It also would be difficult for medical schemes to singularly to each healthcare provider in the country and negotiate a tariff.

So this ruling created a number of challenges in terms of the way tariffs were set, so there was a lacuna in the environment and what then happened is an agreement between the Council for Medical Schemes, the National Department of Health and the Competition Commission about what should happen going forward, given there was no longer tariffs. So the Council for Medical Schemes established a National Health Reference Price List referred to as the NHRPL.

It was based on an agreed list of services and standardised coding. It was based on the BHF tariff guide which I spoke about earlier and was basically adjusted with CPI with some cost based methodology improvements. Medical schemes could use this NHRPL to calculate their own reimbursement levels based on membership and affordability, usually a percentage of the RPR tariff was paid out by medical schemes to providers. It’s important to bear in mind that this tariff set the reimbursement level and that no connection to the build price by providers, so in this environment there was no negotiation.

This is basically the tariff that guided medical schemes, and the provider, on the other hand, could decide to charge whatever he or she chose, the consequence of which is
that members for medical schemes were then faced with this balance billing which is the copayment that we often talk about. So in the absence of penalties for exceeding the RPL, provider groups were in a position of market power because they could basically continue to increase their tariffs with no incentives to curb their fees because there was no negotiation with the schemes in order to be able to do that in any reasonable manner.

In December 2006 the Department then, as per the agreement between the Council for Medical Schemes, the Competition Commission and the National Department then took over this process because it had to become a legislative process. Remember the 2004 to 2006 process was largely a process of fixing the gap. The National Department of Health then published regulations relating to the process of determining the RPL, the reference price list, for comments. So this was referred to the RPL to distinguish it from the NHRPL. In terms of sections 91 (u) and (v) of the National Health Act, and it included costs of labour as part of that calculation.

In July 2007 the Minister then promulgated regulations pertaining to the obtainment of information and processes for the determination and publication of reference price lists. In February 2008 the Director-General then published a notice calling for submissions from all stakeholders contemplated in section 91 (v). These regulations served to invite
your private hospitals, medical practitioners, and medical schemes to summon information regarding the cost of running a healthcare service.

There were clearly a number of methodological disagreements in terms of the way the RPL process had proceeded. I heard a number of stakeholders present to this panel that the Department disregarded the submissions. I would argue, that’s completely untrue. The opposite is actually true. There was actually too much of regard to the submissions and that’s why there were problems with the submissions.

So the first was non represented of sample size in the cost survey. The purpose of the RPL is to try to get a sense about what is the cost of running an average practice in the country. In order to do that you have to make sure that you get a reasonable number of practices across the country that will reflect, to some extent, what an efficient practice in the country should be. Unfortunately many of the submissions did not achieve the sample size calculations in order to be able to do that, so in other words, there was, to some extent, only a cherry picking of particular type of practices that submitted information about their costs.

The second challenge that we had and I suppose on reflection now would be something we would have done differently is the Department of Health did not receive this cost information directly. We had proposed that an independent consultant collect this
information, collate it and submit it to the Department, and that, in hindsight, was a massive error because the associations of the various disciplines then employed the so-called independent consultant who basically prepared the submission on behalf of their masters, and in doing so had to then submit that to the Department, and what we found is that the information that the independent consultant put together was information that was submitted to him or her, as was claimed, and so there was no verification of the information that was submitted. So incorrect cost data was submitted by practitioners, and this was information that we picked up in the primary assessment of the data. We realised that the practice cost data that was being submitted to us did not stand up in terms of what we knew would cause obtaining in the industry in terms of [indistinct] intelligence.

We were then forced to do a verification exercise. We contracted a company called KPMG, the audit company, to go to practices and evaluate this information. So they went to call practices, went there and confirmed whether the cost information submitted to us confirms the information in the practices. In a number of cases in the report of the KPMG, they identified these practices did not exist from the contact details or the addresses, in some case they were directed to a shebeen which was the address that the practice was called to as, in other cases they did not exist, one practice was in Namibia as well, which would not qualify for inclusion.
So the practice cost verification became a massive problem for us because we could not confirm the information submitted was a true reflection of any particular discipline that had submitted information. We were then forced to then apply a CPI adjustment for that year so that we could then do much better studies and review this approach of using independent consultants and actually collect the information ourselves.

Unfortunately that didn’t happen because we were taken to court and I think the panel knows the rest in terms of what happened.

JUSTICE NGCOBO Help me understand the process that was followed here, there are two provisions that are relevant to the inquiry that you conducted, the first one is section 90, subsection (1) (u), which empowers the Minister to make regulations dealing with the processes and the procedures to be implemented by the Director-General in order to obtain the prescribed information dealing with, among other things, the pricing of healthcare of health services. Then you have (v) which empowers the Minister to make regulations dealing with, among other things, the determination, the publication of reference price list. Now, the regulations that were published, did they deal with (u) or (v) or both?

DR PILLAY The regulations dealt with both (u) and (v) because the regulations, together with the guideline document explained how the information should be
collected, how the information will be analysed and thereafter published. The regulations also allowed for the Minister to appoint a committee, an independent committee which evaluated these submissions. So the submissions were not evaluated within the Department, there was an independent committee that provided advice on that evaluation of the submissions. Can I proceed?

**JUSTICE NGCOBO** Yes, you may, thank you.

**DR PILLAY** So if I can move to the methodological disagreements with the private hospitals, our first disagreement was largely around the way the model was constructed. Private hospitals had argued that the regulations as they stood currently, and the approach that we use was largely linked to practitioners of a single practice, and clearly their business is very different and would not fit into the methodology that we had published, and we agreed with that, that clearly a hospital establishment is very different from a single provider of healthcare, be it a specialists or a GP, etc. So in discussing the approach that the hospitals would take, we had the first disagreement in that hospitals indicated to us that they were not going to give us cost information by hospital, so that we could do an assessment of that cost information.

They had proposed that they would appoint an independent consultant who would collate that information and develop a hypothetical model on how a hospital will
operate and what the costs would be. So we had great difficulty with that because we would not be able to verify anything in terms of a hypothetical model. We then proceeded to then agree that maybe we can get the information but the information will be available in a room which we can go and have a look at the information but we cannot take the information out of the room, which would then create an additional problem because we would still not be able to verify that information.

The second area where we had lots of disagreement is around occupancy rates. The hospital argument was that the occupancy rate should be set at around sixty-five percent, our view was that bed occupancy should be set much around, around eighty-five percent, that was optimally where we think an efficient hospital should be. Clearly the lower the occupancy rate the higher the cost per bed day, etc. I think the panel’s aware of the consequence of that.

The other area of disagreement that we had is around this matter of what we call replacement value. It was argued that in costing the cost of delivering a service of a hospital, we cannot use the historical cost of constructing that hospital and its maintenance, we must use the cost of building a new hospital as if it was going to happen yesterday, so in other words, if the hospital was built twenty years ago, we would not use that cost, we would be costing a brand new hospital, effectively, which
for us was difficult to reconcile given that the patients not sleeping in a brand new hospital, he or she is sleeping in a hospital that was built twenty years ago and we would recognise that cost, together with maintenance as what we need to recognise.

So clearly the issues around verification were a problem. Hospitals were unwilling to share a lot of information around cost information such as how many nurses per bed, what were they paying these nurses, questions that the panel asked around agency staff, what were they being paid, etc. that information was information that we were told we were not going to be able to get per hospital, so then we could then verify the correctness of this information.

Thereafter we then had the legal challenge in 2009 and I think the panel is aware of the outcome of that in terms of the Gauteng High Court, the Gauteng North High Court, wherein 28th of July 2010 they ruled that the underlying regulations were determining RPL are found to be invalid. I should point out and I think the panel recognises that these were struck down for procedural matters largely relating to the way these regulations were passed in that the feeling of the court was that these regulations had not served before the National Health Council or there was no evidence that they served before the National Health Council and consequently were struck down based on that. The methodological issues relating to the RPL were not ventilated in any
detail.

**JUSTICE NGCOBO** I understand that, but where are the challenges to the regulations which were not dealt with by the court?

**DR PILLAY** Yes, they were not dealt with by the court, that’s correct, yes.

So since 2010, since the RPL had been struck down, the HPCSA also attempted to set up tariffs, in 2012 the HPCSA attempted to issue a guideline tariff for the determination of fees, and proposed that there should be a 46.6% adjustment on the 2006 RPL and basically called together various stakeholders to propose this the HPCSA tariffs, I should remind the panel, will not relate to private hospitals, but largely to the practitioners that would be within the control of the HPCSA.

The South African Private Practitioners Forum which represents the specialists, predominantly, threatened to take the Health Professions Council to court. Subsequently we then published a discussion document inviting interested parties to participate in a voluntary price negotiation process. We recognised that the RPL process led to a conflictual situation, the information was submitted, an individual practitioners does not know the cost information of his peers, if we come with an RPL there’s always going to be a challenge that this number is too low relative to myself,
etc. So we proposed that maybe the cost information comes together in a mechanism where there is negotiation between funders and providers, facilitated by ourselves to do some technical work around what is the cost information to deliver a service, so that these negotiations can happen in a manner where there is no information asymmetry around costs.

Sadly the private hospital groups, when they were sent the invitations, declined to participate in this process, they had cited concerns around the competition ruling and that they will be charge in terms of the process. The Minister had convened meetings with the Commissioner at the time to seek clarity on whether that was the case, and the Competition Commissioner had made it clear that if the Department had convened such meetings, they did not see any challenge in terms of that, despite that assurance the private hospitals did not participate in this process. Specialists had also then expressed their concern that this process would not achieve its objective because it was largely a voluntary process and they wanted some statutory process to be in place and they also wanted it to be independent of the Department, I anticipate.

So the question is, what has been the market response to the absence of tariffs?

JUSTICE NGCOBO Before we get there, what then became of these initiatives? Did they simply lapse into some coma?
DR PILLAY We received comments, Chair, from a number of stakeholders. I should say that all of the other parties were very much interested in this. I continued to receive phone calls on a weekly basis from providers who say, I have a patient in front of me and I want to know what I should charge him or her, and I say, well, I can't say anything because the RPLs been struck down, they say, well, can't you just give us some guidance because we have no idea what we should charge this patient, and so clearly there is a vacuum in the market in terms of what should happen, but clearly the private hospitals and specialists were not willing to participate in this process.

JUSTICE NGCOBO I mean, the effort to make regulations as you went to section 91 (v) (u), after the court had struck down the regulations, is that where the process ended?

DR PILLAY Yes. We had taken a view that if we published, if we had corrected the procedural matters, taken regulations back to the National Health Council and collected all the procedural issues that the court found to be wanting, and we went back and redid the process, we don't think we would have achieved a very different outcome, largely because the practitioners are very clear to us, we want a particular number. In fact before we went to court on the reference price list, the specialists grouping said to us, if you give us the number we want, we won't go to court. My question is then, do
the procedural matters not matter that you only want to take up the procedural matters only when you don't get the fee you want? So if we went back and redid the process but came up with a number that people didn’t like, but was the number what obtained in the market, we would go back to court for another reason now, altogether, simply because they would find reason why they would want that.

**MINISTER MOTSOALEDI** May I come in?

**JUSTICE NGCOBO** Yes, Minister.

**MINISTER MOTSOALEDI** Yes, because I joined the Department somewhere around this time when this issue was happening and unfortunately I was caught in the eye of the storm, when the court struck, as in slide number 73, when the court struck, made that ruling against the Minister due to absence of consultation, they said the Minister of Health did not consult the National Health Council, it’s a very simple matter. The National Health Council and the nine MECs of Health, together with their heads of department, the South African Military Health Services and SALGA, it’s very easy to convene them within a short space of time. I could have done so then consulted them and go back to the stakeholders and satisfy the court that we have consulted, but my worry was slide 72. Those disagreements, according to me, Chief Justice, are just too much. So I thought before even consulting, as the court has said, we need to clear this
agreement and that’s why I started calling. There were two sort of processes, the first
process was a technical one where Dr Anban Pillay and the team, as Deputy Director-
General For Health Regulations and Compliance had to call the stakeholders to discuss
about this. The second was a political process by myself just to understand whether
there is appetite from medical aid schemes, from providers, and I did call them. BHF
did come. I remember even Discovery came, that’s when I discovered it was not part
of BHF, SAMA did come, some pharmaceutical groups. The problem started with
private hospital because they clearly said, as Dr Anban Pillay has said, that they won't
come and they were citing the Competition Commission ruling of 2004, yes, they were
citing the Competition Commission ruling of, on slide 69, they were saying because of
that ruling it will be illegal for us to meet with us and discuss any matter which is to do
with pricing, and they demanded a letter, a written permission from the Competition
Commission in order to come to such meetings, and when I consulted the Competition
Commission they were not willing to write such a letter. I think it was very
problematic for them, and at any rate they said their ruling in 2004 did not preclude
from people sitting to discuss differences like this, but the private hospitals insisted. I
then approached the Minister of Economic Development, because that’s where the
Competition Commission reports, my thinking, Judge, was to ask the Minister, I'm
confessing in my ignorance at that time, to ask the Minister to instruct the Competition
Commission to reverse this ruling, because I said, this ruling is very bad for health. Everything started being expensive after this ruling. I used to call it the law of the jungle, we know longer know whether we’re going or coming, it’s the law of the jungle and we really need some form of help. So the Minister said, look, Minister, I don't understand much of these things, all I can do is to convene a meeting with the Commissioner and yourselves, sit and discuss these issues, if the Commissioner understands, as a Minister, I won't stand in your way. Unfortunately, Chairperson, it took me three years. Those meetings took three years with the Competition Commission, because eventually they said, because in my thinking, let me tell you what I was asking for, all I was asking for was to reverse the 2004 ruling, in my thinking I was believing once they reverse that ruling the law of the jungle will go, order will come back within the system, and the prices will revert. I'm no longer sure whether that was correct but that was my thinking at that time, just reverse this ruling then there’ll be order within healthcare, otherwise we don't know whether we are coming or going. But as it said, the Competition Commission was not willing. Instead that is the time they said, maybe let’s test your post [indistinct]. Is it really true that private healthcare is as expensive as you’re saying or because of that, and I think that’s where we are today, but it took me three years of having constant meetings to talk to them about this issue.
So during that process we had all these things that Dr Anban Pillay was talking about.

So up to today we still have not made any inroads, obviously.

**JUSTICE NGCOBO** At least you are here today.

**MINISTER MOTSOALEDI** Excuse me.

**JUSTICE NGCOBO** At least you are here before us.

**MINISTER MOTSOALEDI** Yes, yes, at least I'm here at long last.

**JUSTICE NGCOBO** I wanted just to understand it, since 2010, July, after the ruling, nothing has been done in order to take the issue of making regulations [forward] other than the meetings with the stakeholders, which they’re unwilling to attend, and meeting with the Competition Commission over a period of three years.

**MINISTER MOTSOALEDI** When they Director-General presents she’ll show all the regulatory, it will come.

**JUSTICE NGCOBO** Okay, but insofar as the pricing is concerned.

**DR PILLAY** In terms of the pricing, Judge, our approach was that clearly the current provisions that are available in the National Health Act, section 90 (u) and (v), require a significant amendment in order to be able to achieve the objectives if we want to
come up with some regulatory regime. My first difficulty, I suppose, with the current
construct, given our experience, is that providers are not obliged to provide this
information. The consequence of providing inaccurate information does not exist. The
consequence of providers who exceed the tariff does not exist. So if we came up with
any other tariff without these obligations on providers to be able to comply with the
legislation, it would not be effective relative to what it could be. So in other words,
providers could simply refuse to provide the information. They could provide false
information and we would have great difficulty in trying to resolve those matters as we
had been. Thirdly, even if we came up with the correct tariff, as providers had said to
us previously, what stops me from charging three hundred times that, and they did, and
so the question is, how effective would that be. So we’d need to have some process
because the consequence of this for the public is that if you charge three hundred times
the tariff and the medical scheme paid less than that, the patient faces a copayment at
the point of service, which is the real challenge for the public.

**DR VON GENT** Can I still have a point of clarification, Minister? So you spoke to
the Commissioner for three years. All those three years, did you try to get the 2004
decision from the table or did you try and get immunity for the parties to talk to you
about a new regulatory regime of the industry, because these are two totally separate
subjects, isn't it?
MINISTER MOTSOALEDI  Well, the Competition Commission told me that no immunity is needed. That one, they discarded long ago. The debate was about me telling them that the Competition Commission ruling of 2004 misunderstood the health sector, that the Competition Commission did very well. The Competition Commission was very popular in South Africa. They have just brought down the big guns that were cheating the nation and I was also very proud of them, but I was trying to convince them that health is a different field altogether. You can't apply the same rules. That’s where the problem is, because they could not understand that there is any area of their operation which is different from the others, and they believe the normal rules they apply in the normal markets must also apply in health, and I had a very big problem with that.

DR VON GENT  The reason why I ask is I can understand your objective to explain to the Commissioner why health is different, but you don't need the Commissioner’s consent to talk to the industry, is it, or the industry doesn't need the consent of the Commissioner to talk to you about the principle of price regulation cooperation with you on price regulation.

MINISTER MOTSOALEDI  That was my position but that was not the position of industry. The position of industry was that I must, not industry, private hospitals,
specifically, was that I must bring a letter written by the Competition Commission that says such a meeting can take place. It was not my position.

DR VON GENT That’s right, and the letter could not be written by the Commissioner, that was the point.

MINISTER MOTSOALEDI No.

DR VON GENT Alright.

DR PILLAY I should just clarify that the letter could not be written by the Commissioner because the Commissioner’s view was that this industry could seek approval from the Commissioner about whether this practise would be acceptable or not and clarify that, but providing a letter may lead to ambiguity about how negotiation could go on, and what the Commissioner was agreeing is that the Minister has the right to always convene these meetings and he didn’t see a problem with that, but any letter written may be construed differently and so he said why did they not seek a meeting with me to clarify these matters.

If we can move on to the matters relating to what has been the market response, so we can now talk a little bit about the supply side response. So the PMB regulations required that medical schemes pay the provider in full. This is regulation 8. So
regulation 8 has been around for a long time but regulation 8 in the absence of a price guide is open to abuse, so in the absence of tariffs for providers, this was used, the price of services for PMBs became higher relative to non PMBs. What we also saw was that the classification of conditions as PMBs when they were not PMBs. Now, firstly the Board of Healthcare Funders had drawn our attention to the fact that in the absence of the RPLs, that medical schemes were facing a significant cost pressure because the PMB tariffs were increasing significantly and argued that regulation 8 was the cause of this problem and regulation 8 needs to be clarified and that regulation 8 says pay in full but the pay in full in terms of what was intended by regulation 8 was in the context of some price regulation or price guide. Now that the price guide is absent this is posing a problem.

The BHF then approached the court for a declaratory order on the interpretation but what this did is that then this drew the attention of providers who were not aware of it at the time maybe, that actually this is harvest time, as some say, and you now have an opportunity to charge whatever you like because the medical scheme has to pay, simply because it says payment in full and post the declaratory order is what you see is a specialist rate for PMBs which continue to occur simply because in this context specialist continued to charge whatever they feel like.
If I can come to the next area which is what’s called upcoding, and here we took the first example and this was provided by Insight Actuaries, looking at data from medical schemes, looking at major depression and bipolar mood disorder. Again, if you look at the 2012 data compared to the 2013 data you see a significant increase in bipolar mood disorder and a relatively similar decrease in major depression. So the question is, did something happen in South Africa between 2012 and 2013 that caused South Africans to develop bipolar mood disorder but there was no more major depression, and if we can try and study and understand that it will be very helpful because maybe we can enlighten the world about what really happened.

MINISTER MOTSOALEDI  Sorry, Chief Justice, I think this is a matter of much more national importance than the Deputy Director-General is putting. It’s very serious for me. Well, firstly let me state, when the Board of Healthcare Funders wanted to go to court about regulation 8, I totally discouraged them because they said they wanted clarity about regulation 8 and having known what the 2010 court ruling did to health, I was saying, you must stop running to court every time there are problems because as Health we need to sit and set our policies, our policies cannot be set in a board. Not that I was undermining the courts of law, I was just saying health policies and what must happen in Health is better determined by the people involved as stakeholders, because they were there every day because courts do rule on the basis of
what they see on the letter and rule of the law. So I said if there is a misunderstanding of regulation 8, why don't you allow me perhaps to go back to parliament and put it in clear black and white what actually this means so that it becomes a clear regulation. They said, no, that will take time, we want the decelerator we want the court to issue a decelerator of what the regulation 8 means. I even called the Council of Medical Schemes because the Council reports to me and is being taken by BHF to court. I said please sit and work together on this thing, I'm prepared to go to parliament. Unfortunately the Board of Healthcare Funders was determined to go to court and they did go to get that decelerator. As my worst fears were confirmed, this started happening after the court ruling, as Dr Anban Pillay is saying, but the part which I said is of national importance to me, Chief Justice, look at this slide, this slide is saying because PMBs are paid in full, I'm a doctor, I don't want to struggle, I want to be paid in full and be paid any amount of money as the decelerator is saying, and if I diagnose this patient to be having major depression, which the patient has, I'm not going to be paid, so I must change the diagnosis and say this patient has got bipolar. Now, that is very serious to me because you are apportioning a wrong diagnosis to a patient in order to get paid.

I will tell you why this is serious. We have got a very big and very depressing politic debate here in South Africa about a letter written by former President Mbeki, as
everybody knows. That letter is resting on three issues which are very unfortunate. Well, the first one is just his misunderstanding of what a symptom and a sign is. That’s the first one but that’s not the issue. The second one is based on the belief that HIV Aids was number nine killer in the country and it was being given undue attention. I know that happened to me in 2009, because the Stats South Africa, I don't know whether, when they released their report, when they released stats, was actually showing, I don't know where number nine is, the document I've seen was number eight, because I was accused of looking for more money for HIV when it’s only number nine killer, I tried to argue with them. They said, no, but we got this from Stats South Africa, it gets it from diagnoses of doctors. I tried to argue with them at that juncture because there was Aids denialism, there was a lot of stigma. Insurance companies were literally refusing to pay for somebody who died of HIV and Aids. So communities were pleading to doctors not to write HIV diagnosis. Now, doctors did not. I don't know whether ethically or morally that’s correct, but they were trying to defend the patients at that time. Unfortunately Stats South Africa took it and they said HIV is number nine killer when it was actually number one. So these things do change the way things are perceived and the laws of the country and policies.

Where does bipolar come in? This which is happening here, which is in essence it means a court ruling changes an epidemiology of a country within no time, because
epidemiology has to do with the study of the pattern of disease, their occurrence, their prevalence, incidence, etc. that’s epidemiology. This means the epidemiology of a disease has just changed. South Africa, in a stroke of a pen, has moved from people who suffer major depression to bipolar. Now, Stats South Africa is going to pick this up, there’s no question about it, they will pick it up, put it as Stats South Africa ruling, Professor Fonn, your PhD students will pick it and get their PhDs on the basis of a lie, because somebody was looking for money. They will get PhDs on this, the World Health Organisation will pick it, as from South Africa, it will go to United Nations, and take it from me, it’s difficult to change statistics from United Nations. We’ll become number one bipolar country in the whole word, and that will be official, and in my thinking, which investor would like to invest with a population that is fully bipolar everybody, you know. This has got very serious implications, so that’s why people hear me being very emotional about PMBs because this is what they produce, changing the whole fortunes of a country, even in the international arena. Unfortunately this is what we are dealing with. Dr Anban will show same thing is happening with anaesthetics.

**DR PILLAY** If we go to the next ...

**JUSTICE NGCOBO** It’s not the court, though, that changed the name of the disease
but what happened is that the major depression is not covered by the PMBs. Is that right?

MINISTER MOTSOALEDI  Yes, Chief Justice.

JUSTICE NGCOBO  And only bipolar is covered.

MINISTER MOTSOALEDI  Yes.

JUSTICE NGCOBO  Therefore in order to get the benefits, people are diagnosed with bipolar.

MINISTER MOTSOALEDI  Yes.

JUSTICE NGCOBO  But that’s not the only instance where there appears to be a misuse of this benefit. We were told over the last couple of weeks that in order to get benefits, patients are being admitted to hospital in circumstances where admission is not required, simply to get the benefits.

MINISTER MOTSOALEDI  Yes, Chief Justice.

JUSTICE NGCOBO  That’s what the doctors told us they do.

MINISTER MOTSOALEDI  Indeed it’s not the court. I was just trying to show it happened after the court ruling, they were making use of it, as he said, for opportunism.
It’s not the court that caused this, yes, but I'm just saying it’s because the ruling was giving them an opportunity by law that if it’s a PMB, pays by full. To me, actually this is fraud, it’s a wrong diagnosis, fraud. The other one you are mentioning I may add another reason because I said earlier I’ll mention it, about people being admitted. The World Health Organisation said we have got admissions that are unnecessary. I heard from the private hospital group trying to argue it’s because of age and many other things, they said most of the admissions are unnecessary and for a short stay, and Dr Norman Mabasa, one of the private practitioners who was once the chairperson of SAMA but who was presenting, as he said, he said he’s presenting as an ordinary citizen, but I'm afraid he end up presenting as a doctor anyway, but that’s not the issue I'm raising, he actually showed that because at the moment we are hospicentric the private hospitals have won the power, they are holding the power, they are pulling everybody. So when medical aid schemes budget, they budget more money for the hospital because they know that’s where the costs are. So primary healthcare money is very low, the percentage is very low. So what Dr Mabasa was saying, if a person comes with tonsillitis in January, as a private practitioner, a general practitioner, you can treat that person because there are benefits to private practice, but they usually end in March or April because it’s a small amount of money, now your only avenue is to admit, because there is still money for hospitals, for once you are inside the hospital.
So the only avenue is to admit this person to treat them, meaning the same patient coming to you in January who you can treat, in May you may no longer do so. So that is also because of primary healthcare has actually been ignored. That’s why the graphs I show, show that the share of GPs is going down tremendously, even medical schemes are sucked into that instead of solving the problem. In other words, instead of having a way to challenge or to match the private hospital groups, they are not able to do so, they look for the weakest. I personally believe, yes, they are very strong. I heard when you’re asking them about negotiations, those negotiations are one sided. They have developed a lot of power and Dr Anban Pillay was showing. My understanding is that they got that power during market concentration, in other words, they were building muscle and my understanding was that 2004 found this body with big muscle and injected a steroid in it, you know. When you have got a huge volume of muscle and you inject steroid you become even stronger. That’s why I was chasing the Competition Commission that perhaps if you reduce what you have done, you know, that power which they unleash to everybody will be very problematic.

So there are quite a number of things, including this once, including this PMB, but also including the fact that GPs are being pushed out of the system and our costs are going higher and higher because of that, and so the cost of bipolar is just increasing.
Chief Justice, let me also inform to you, unfortunately I didn’t have the letters, many patients don't like this idea of PMBs because even specialist groups, I was written in 2009, unfortunately I misplaced the letter, by the Arthritic Association, Minister, explain why arthritis is not regarded as a PMB. We understand PMBs and I said, no, I understand PMBs are life threatening, but then they will show you, no, but infertility is a PMB, it doesn't threaten anybody’s life, it just brings a lot of major depression, not bipolar, but depression, but it’s not a PMB, and so why do you say PMBs are only life threatening, and they said we can show you lots of people on wheelchairs who cannot walk because they’ve got arthritis, that is a PMB. Then from there you start getting more and more letters, meaning what, people don't appreciate why some diseases must be regarded as PMBs and not others, meaning the system doesn't work because it’s a zama zama, as I said.

**DR PILLAY** If I can show a similar effect, in this case we’re looking at anaesthetic services, and what you see is that over time, from 2007 through to 2014 that the anaesthetic services for PMBs, the cost is very much higher than non PMBs and clearly in the case of anaesthetic services, a very clear example, there should be no real difference between the PMB versus a non PMB in this case. So clearly there is, what we call, upcoding in the case of anaesthetic services as well.
So what has been the effect of the private market on the public sector? Because I think this is another area that the panel has been trying to explore, and we’d like to raise this, because it’s often been said, well, it’s our money, it’s private money so why do you in government bother about it because we can pay whatever we feel like paying and it’s okay. The reality is that it’s not okay because whatever is spend in the private health market has a direct effect on the public sector.

Firstly, let us talk a little bit about what we call cream skimming and dumping. In the private sector we would argue cream skims is the healthy and wealthy and dumps the sick and poor, and we're going to provide you with some examples of patients that were transferred to the public sector when their medical scheme benefits were exhausted. Patients with suspected infectious diseases were diverted to the public sector as well, and we have examples of, particularly in the case of Ebola and TB, you heard from KZN as well around this. So here are examples of patients. We have many more and I think a number of public sector clinicians would have liked to come to the panel to share with you their personal experiences of private sector patients being transferred to the public sector the moment the medical scheme benefits have been exhausted. So Patient A required a full cardiac assessment and probably an angiogram. The medical scheme did not authorise the procedure although it is a PMB procedure. Patient B requires a full cardiac assessment, assessment of his pacemaker and
replacement of the pacemaker, patient was told, well, your medical scheme is exhausted, your benefits are exhausted and the patient was transferred to the public sector. Patient C had a recent heart attack treated as an emergency in the private sector, the patient was then told you’re not going to be able to afford care here, we’re transferring you to the public sector and the patient was transferred. This is just examples from one hospital and I think my colleagues in the provinces had indicated they don't routinely collect this information, but if they were actually routinely collecting this information the picture will look a lot more serious than this.

**MINISTER MOTSOALEDI**  May I be allowed to add a few more examples on this issue because it does trouble us quite a lot? As I have said earlier, I do collect my treatment and go for check up on a monthly basis at Steve Biko Academic, and they take this opportunity to complain to me. Almost on every visit, Steve Biko Academic Hospital is complaining to me about what actually is happening to them, where they just get phoned during the night and say we are transferring this patient, and all of them, it’s because the money is finished. Quite often, Chief Justice, when they arrive they have got no money because they have left all the money, it’s like somebody taking your money and when you are poor you must come to me for treatment, you must be referred to somebody else, and you are not going to pay there because your money has already been taken. They are never referred here to us, to the public sector with their
money, and that’s very unfair. But quite often to members of the public it’s always the private sector coming to the rescue of the public sector, as I heard them, they were gloating this morning, Netcare was gloating about what happened during the strike, that they are really saving the public sector. I want to put it to this Commission that that is not always the case. It’s only because there were so many problems in individual facilities, people believe nothing there is happening.

Let me give you the example. This patient was on a health plan, you know, not a medical aid, health plan which every morning after eight o’clock it’s on TV, you’ve got pain, if you get sick, R1,000 a day, you know, now this poor patient believed and did that. The patient needed neurosurgery because the cerebral spinal fluid pipe had blocked and the health plan said, no, we can only give you R50,000. When they advertised they say we give you R1,000 a day if you are in hospital. They said no, you can go, we’ll give you only R50,000. The private hospital said no, no, we want R250,000. So there’s a gap of R200,000, and they said this gap must be filled in by the patient, the patient, she must go and look for R200,000 for the private hospital because they said it’s none of our business that the health plan will give you R50,000. Eventually this lady was feeling very dizzy, she could not stand up and I was phoned and we took this lady to Steve Biko Academic Hospital the neurosurgeon did that
operation, she’s back home, at work. I don't know what happened to the health plan, whether she went back to tell them about their lies, I don't know.

Even patients in emergency situations, this patient had a head injury, a scan was done in a private hospital, they indeed found that there’s a clot in the head but they wanted a deposit of R1,000 before they could do the operation. They literally said, we’re not touching you until you put R1,000 here.

DR PILLAY  R100,000.

MINISTER MOTSOALEDI  Sorry, did I say R1,000? Oh, I withdrawn, R100,000, yes, it’s R100,000. Now, the poor patient started raising funds until he could only afford R60,000. Still the operation was refused. When this patient came to us, that R60,000 was left in whatever private hospital and we took this patient to George Mukhari where they removed the blood clot.

I'm mentioning these things because quite a number of people believe it’s a one way train that the public sector is messing up and the private sector is correcting.

Now, we had to help him go back, go get the R60,000 back but I'm trying to say these types of things happen again and again and again.
Then issues of workforce, on this slide. Eighty percent of the specialists in this country are in the private sector serving sixteen percent of the population. Obviously the poor who are the greatest majority do not have access to these specialists and that’s why we want both public and private sector to be utilised by the country, and after taking eighty percent of the specialists they come and say, no, compete with us, you are not, you know, I heard some of the stories here that, no, the public sector is not giving us a match and all that. We only have twenty percent of the specialists of the country and they’re serving eighty-four percent of the population who are very sick people, as you have seen when we were showing the slide about Pintal.

Now, the other issue is because private sector is able to offer higher salaries indeed, the government eventually introduced OSD. If you look at OSD it’s in favour of specialists because we wanted to keep them. We did not want them to leave because otherwise there was going to be no specialists at all in the public sector. Then came the issue of ARUAPS. I think, Chief Justice, you have decided ARUAPS, you have discussed ARUAPS with a number of hospitals here, and I'm sure, I'm sorry they’re not telling you the truth. This thing is a monster, a very big monster that is destroying the country, I must state. ARUAPS is a system that was asked for by unions after 1994 when they claim that the public sector is not paying professionals, it only pays you if you are a manager and I must state on record that that situation has changed.
Professionals earn more than managers now in the public service. That situation has changed but that song is still being sung that we need to ARUAPS because we are earning nothing. Now, the ARUAPS were given. For nurses it’s moonlighting which was not necessarily given but ARUAPS is supposed to be official but it’s fully abused. You are going to ask me a question which I heard you being asked, Chief Justice, why don't we regulate, and I'm sure you heard with provinces here that Western Cape is better able to regulate ARUAPS than other provinces, like, for instance, Eastern Cape. The game at play is this, it’s not that people in health don't want to regulate, they are completely blackmailed. In a situation where doctors know they’re in great, great short supply, they threaten, they threaten on this issue of ARUAPS. Let me give you one example. At University of Pretoria, Steve Biko Academic Hospital, the Department of Anaesthetics, some lecturers, not the whole department, in anaesthetics, knowing very well that no operation can be done without an anaesthetist, just demanded, that they demand, not even ask, that once a week they won't come to work, they’ll be going to do ARUAPS, and when the hospital told them, no, you can't, you’ll collapse the services, they said, we’ll leave, we’ll go to the private sector, we are wanted there, and there’s a lot of money there, we’ll just leave you, the best thing is for you to allow us, and of course out of fear they were allowed, but the other specialists fought, because if you are a surgeon you can't enter theatre without an anaesthetist. If you are a
gynaecologist or obstetrician, it just wrecks the whole system, but that’s what happened, and they were forced to take action and six of them left. They had thirteen lecturers, six of them left, they took eighteen months to get that number. So I just want to tell you that they are threatening this thing. It’s not as innocent as it looks.

The other example I can give of ARUAPS, when University of Limpopo was still linked to Medunsa, I'm sure you’re aware we demerged them, Medunsa sent lecturers to Mankweng Hospital in Polokwane, where the students are because they sent lots of students there, they need to be taken care of, those students went on strike because they had no lecturer to teach them. The lecturers come for one hour and rush over to Mediclinic in Polokwane. You asked this question to Mediclinic and they said they were not aware of that. They are very painfully aware, because the CO of the Mediclinic Polokwane was asked whether it’s true that these people are here. They confirmed, they said, yes, they are always here, we thought they made a deal with them. Some of them are professors, actually, who were going to Mediclinic and leaving the medical students alone.

Then the third example, Walter Sisulu Medical School under Nelson Mandela Central Hospital in Umtata, that’s a far rural area, I accept, where it’s not easy for academics to go. That’s where they blackmail you because they know you want them more than
anybody in the city. That’s why Western Cape will easily control them because they can tell them to go and jump, but in Umtata you can't, Umtata, you can't say so. What happened, the former Head of Health in the Eastern Cape, Dr Siva Pillay discovered with information given my medical aid schemes that some of the academics there are charging and getting more money from medical aid schemes that doctors in full time practice. You are employed as a lecturer at the university, you are working at Nelson Mandela Central Academic Hospital, Umtata, but the claims you are making on medical scheme is much higher than a number of people in private practice full time. So he took that information to the university to take action, and he was stopped by the university, the council, because their fear was these people will go away, what are you going to do, then it means the medical school will close. They literally stopped him.

Now, on my side I’ll be asked, what have you done, Minister? I've been talking to deans of medical schools for quite a long time. We spoke to SAMA. SAMA played ball. They produced a document on how these ARUAPS must be controlled, because here we wanted consensus because if people just threaten and threaten to away, you don't really just force them by law, you need consensus. SAMA developed that document, the people who are holding us back are the deans, quite a number of them are scared, and their fear is what will happen if the lecturers go away, look at Steve
Biko, they took eighteen months, look at ... Others are saying, but these people are
gone already, they are lecturers in our university but they are gone.

What are the results, Chief Justice? Medical students are not getting the training I
bought. I was a medical student thirty years ago. I had the benefit of all my lecturers.
I didn’t have to compete with any ARUAPS because there were no private hospitals.
Everything that I supposed to have been taught I was taught very well and the medical
students are not getting that benefit. Now the story was going around here that, no, we
are not training enough medical students, private hospitals want to do it on their own,
that is what in medicine we call dissociation, Chief Justice. Many people know a
defence mechanism called denial. They don't know that there’s another one called
dissociation where you dissociate between cause and effect. You cause problems but
you go and laugh at the person having problems, because this problem is caused by that
but they come back and laugh at us, look, you're not efficient, look, you're not doing
well, you are not training enough doctors. They are the cause of this problem and it’s a
very big problem for me.

Now, I promise that on this juncture I'm going to bring the issue of Lesotho because it
has been raised as a PPP. Let me start by saying, Chief Justice, the Minister of Health
in Lesotho, Dr Monyamane, gave me a document, a huge file in October last year, right
here. We were having a meeting here in Cape Town, of China Africa Forum, he gave me a big file and said, Minister of Health, you guys in South Africa, you are big, you are a big brother, you have got lots of lawyers, you have got lots of senior counsel, silk, huge, a strong constitutional court and strong courts, you have got a lot of money, please take us out of this contract, it’s terrible. I know it has been defended here during the day. I'm told by the person who is supposed to be part of that contract, he said take it out. Today when it was being [mooted] here as one of the best, I phoned you, I phoned the Minister, when I went out of here, I say, Minister, you said I must take you out of this contract but you are partners in this contract, are pacing it. He said, Chief Justice, I must make a request to you, and the request is that he wants to come to this Commission to talk for himself, if the law allows. He said so, he said, I don't want anybody to talk for me, I want to talk for myself, so go and make a request to the Chief Justice if I'm allowed to come. So I'm officially making that request because he said he will explain exactly what’s happening.

The other thing, I'm sorry, Chief Justice, I then wished that before we talk here we raise our hands and take some oath that will tell the truth and nothing else but the truth, but unfortunately the rules of the Commission is not how it’s committed. A story came out here that in that deal an extra patient is charged R1,500, that has been cut by fifty percent, it’s actually R3,000, that’s what I got from the Minister. In other words,
Netcare is telling Basotho that we are running a hospital, provided you don't give us more than twenty thousand patients, in other words, only twenty thousand Basotho must be sick in that year to need this. If it’s one more, it’s R3,000 more for each one of them. It’s not R1,500, I want that to go on record.

The other thing that I can't, I can't copy this type of scene, which is, I mean, we just said you must copy, the other thing, this deal is taking thirty-five percent of the Lesotho budget and this was made by, information was given by Lesotho itself, Oxfam, the NGO in England, wrote a report that Lesotho is spending fifty percent of their total budget on this hospital, and Lesotho itself responded, they said it’s not true, it’s not fifty percent, it’s thirty-five percent of their total budget. The total budget of Lesotho is for health, it’s 1,700, and what they must Netcare is R600 million per annum for this deal. I saw, they were showing the Queen Mamo Hospital, that is shining, and Queen Elizabeth, that is dilapidated. Then of course you’re also cheating people psychologically, they’ve got Queen Elizabeth Hospital, you say, yes, yes, she will build you a new hospital, that has even got a colonial name, we’ll give you this hospital in your own queen, it’s Queen Mamohato, but an ordinary Mosotho cannot afford it, and the Minister said, this has largely affected their budget of primary healthcare, they can't provide primary healthcare. What business does it have to do with me? Because the flow over the borders, it affects me.
The other thing that you were not told, that they hire doctors directly, in South Africa we refuse to hire doctors. In this occasion the Basotho specialist refused to come on board. They said the deal that was being made to them was unacceptable. The doctors hired there to run that hospital are from DRC, are from Pakistan, are from Bangladesh. They’ve just brought interns from Malawi, which is quite unacceptable. They just brought in interns from Malawi. These other people are running that hospital. That information was not brought here. The results, quite a number of procedures which Basotho were doing for themselves because they have got specialists, they are sending to Universitas Hospital and Pelonomi in Bloemfontein. As I'm speaking now, they owe us R86 million. In other words, Basotho owe us R86 million, they pay R600 million per month but they must also pay us because they can't do these ordinary procedures, there are no doctors there to do them, and the debate now is who must pay that money. Is it part of this deal or was it be paid, but Free State has not yet been paid that money and they are still busy negotiating it. So I just want to say not everything is glossy, as they are saying, about these issues of PPPs.

The other example ...

JUSTICE NGCOBO The individuals who required those operations from Lesotho,
they are sent to South Africa.

**MINISTER MOTSOALEDI** Yes, Chief Justice.

**JUSTICE NGCOBO** Are they sent to Netcare Hospital?

**MINISTER MOTSOALEDI** They are sent to Universitas Hospital, our own central hospital is public in Pelonomi, they’re not sent to Netcare Hospital, they are sent to a government hospital in Bloemfontein and that’s where the procedures are made, and I do have a list, if the Chief Justice wants. Free State has just given me a file of all the patients, the dates, the quote, and the amount of money that was charged.

The other issue I want to deal with, Dr Bhengu, yesterday asked Mediclinic about transformation and you were saying you looked at three of their hospitals, out of a hundred doctors, only seven are African. Their answer was that, no, if you go to Polokwane that’s a different story, we did transformation. Let me tell you the story of Polokwane. When black doctors, because of a new democracy, a new constitution started getting to Polokwane to practise at Mediclinic, they were struggling to get beds. Even those who were given beds were not given theatre time. That is a fact. The black doctors then came together because they said this is becoming very difficult, they came together to contribute money and start their own private hospital because they said we
cannot survive here, and when they did that they even bought a piece of land to start that private hospital, and the Department of Health in Limpopo gave them a licence. Mediclinic interdicted them. They went to court to stop them because they said they need extra beds in the Mediclinic facility in Polokwane. Nobody else should get a licence before they get those beds. Well, there was a negotiation, that matter never went to court, but they were interdicted. After that interdict they thought they could get help from the other private hospital to defeat Mediclinic. They went to Life Health to partner them. Life Health was not interested. They went to Mediclinic, I mean, sorry, to Netcare, it’s Mediclinic that is taking them to court from having a licence of hospital, they go to Life Health, Life Health declines, then they go to Netcare and say partner with them. Netcare agreed but they tell me they disagreed in terms. Firstly it was their licence and Netcare demanded a majority share. That’s the first thing. The second thing, they demanded that all must leave their practices, all of them who were wanting to build this hospital have practices all over Polokwane, they said they must leave their practices and come and have their premises in the new hospital if Netcare is going to be their partner and thirdly, that if they have to admit any patient they can only admit to this Netcare facility, not to the Mediclinic. Then they said, no, we thought if they are going to be a true private hospital, we must have a choice, as doctors, and the patients must also have a choice. They tell me Netcare said no and that’s when there
was a disagreement, and this whole thing collapsed. Now, the doctors who told me this story are prepared to come to this Commission to come and take the file. It collapsed, and guess what, after it collapsed Netcare got another partner called Pholoso, a group called Pholoso was given the licence, but if you go there to Polokwane you will see it’s a Netcare hospital. You were asking here whether licences can be traded around. In Limpopo they are not allowed to. I asked them why did you allow this, they said, no, as long as the original group we give a licence is still around.

Then the day hospitals that they are talking about, there’s a day hospital in Polokwane which was given a licence very recently, they sold that licence to Mediclinic. Limpopo has gone to the Competition Commission to challenge that. I just wanted these facts to be brought here to the Commission because the Commission has not been told the real story of what actually is happening. In my understanding, no small group is allowed to come on board, proving what Dr Anban Pillay was showing here, that in market concentration you don't allow small players to come on board, and regardless of what you have been told here, all the small players who might be giving affordable healthcare, including day hospitals, independent hospital groups, I'm not allowed in the system. I was also called by the National Empowerment Fund, you get this story from everybody, you can call them, they told me that every time they funded a black BEE group to build a small hospital, they found a way, they find a way to get them. I heard
Netcare here talking about the Waterfall Hospital as one of the issues that they’re done with BEE, that licence was given to [Rauteng] to a BEE group. I don't how he ended up with Netcare. Maybe [Rauteng 9.01.28] must come and explain, but I just thought it’s important to mention these issues.

And we don't hate PPPs, Chief Justice, the fact is that in 2010 SCOPA the portfolio committee in health in parliament, together with the portfolio committee on correctional services approached the cabinet and complained that there’s a concept called PPP in this country, and they said we have checked all the PPPs, you don’t know why you call them partnerships because there’s always one loser, and that is the state. They said there’s not a single PPP where the state is not losing, it’s always the loser, and even on the Lesotho one the state is the loser as the minister wants to come in, you know, and we know what happened in what they call the Folateng units at Charlotte Maxeke Academic, it is the legislature [Rauteng] that said we must cancel those Folateng units because they were not serving the members of the public very well.

JUSTICE NGCOBO Mr Minister, for the record, the technical team will get in touch with your office to get the particulars of Dr Monyamane, the Minister of Lesotho.

MINISTER MOTSOALEDI The Minister of Health in Lesotho.
JUSTICE NGCOBO The Minister of Health in Lesotho, as well as the documents that you referred to from the Free State facility.

MINISTER MOTSOALEDI Okay.

JUSTICE NGCOBO And the particulars of the doctors from Limpopo who are willing to come and testify on the issue of the licences.

MINISTER MOTSOALEDI I will do so, I will do so, Chief Justice. Thank you.

Now, the public sector. I started with the private sector for obvious reasons, but we do also have a public sector here, and I'm a minister for both, if I may remind those who believe we are only in one side. What I want to show about the public sector is that the general narrative is that the public sector is collapsing, and I said, I was just showing that it is not necessary to, part of the narrative stems from a completely wrong definition of what health is. People who propagate this narrative see health as limited to what happens inside the hospital. They see health as only clinical medicine with particular emphasis all [what] health services inside the hospital, which is exactly what Netcare was showing. They took good, very good, extremely good hotel services to Lesotho, but not clinical services. I must argue, that’s what the Minister is going to tell you. So the issue of what is good is about hotel services which in most cases in the
private sector are extremely good indeed, they can even be world class, we’re not challenging that, but if we put health in perspective, there is also population health here, commonly referred to as public health, but there’s also clinical medicine, as I said.

In South Africa people who are propagating the narrative of collapse are deliberately and sometimes conveniently, very conveniently ignoring the youth strikes made in public health. So let’s examine the facts. If you look at 2009 and 2014, those are the figures about life expectancy, under five mortality, infant mortality, neonatal mortality, you can as well see for yourselves those figures, that we are making inroads there.

Also ten years ago we had only four hundred thousand people who were on treatment for, who were on ARVs, today is 3.4 million people who are on treatment, it’s the biggest in the world, and ten million people are tested annually for HIV and Aids. The programme for prevention of mother to child transmission did miracles. It reduced mother to child transmission from eight percent in 2008 to 1.5%. If you go back to 2004, seventy thousand babies were born HIV positive in South Africa every years, seventy thousand. We worked very hard over a period of five years on mother to child transmission of HIV, the figure is now below seven thousand.
We have made progress on TB. In 2009 the TB cure rate was sixty-seven percent, it’s now eighty-two percent. Of the number of people who are on what is called Isoniozid preventative therapy, this is a drug given to people who are HIV positive to stop them from developing TB because the two diseases usually go together. Of all the people in the world who are on Isoniozid prevention therapy, sixty percent are in South Africa, we are responsible for sixty percent of the world programme. Fifty percent of gene expert, gene expert is a diagnosis for TB, the first time in fifty years, very highly sophisticated, fifty percent of all the tests on gene experts are conducted in South Africa. The issue of multi drug registered TB, the treatment with Betagalen, sixty percent of all patients are on Betagalen in the whole world are treated in South Africa. That’s why, Chief Justice, next week I’m travelling to the United States of America, I am going to be getting a prize, an honour, together with the Minister of Health from Pakistan and Professor Paul Farmer, professor of infectious diseases at Harvard University, at the USA 2016 World Aids Day, a celebration on the 17th of March, we are going to be given this prize. Now, I am just emphasising these issues because I our system is said to be collapsing. We also have issues pertaining to what you call MomConnect, but before we come to MomConnect, let me come to child deaths through diarrhoea. We are the first country on the African continent to introduce Pneumococcal vaccine in rotavirus. Rotavirus vaccine has decreased death due to
diarrhoea by fifty-six percent. The Pneumococcal vaccine has reduced hospital admissions by seventy percent and deaths by fifty-three percent. We also have, as you know, human papillomavirus, where we are vaccinating young girls below the age of nine.

Of importance is this issue, Chief Justice, when you read papers every day, everything is collapsing, we have got a programme called MomConnect, it’s registering pregnant women on the cell phone, we communicate with them on a weekly basis, we send them messages, whether the pregnant woman is going to public or private, telling them what to do during their pregnancy. We also encourage them to lodge complaints or compliments. Now this is unsolicited, it’s not research, you’re getting it from a woman herself. We now have eight hundred and seven thousand women, there are 744 complaints and four thousand, six hundred and thirty-nine compliments. The complaints, he said, I went to this clinic, these are my problems, this is what I was unhappy about. The compliments is to say, I'm very happy about the service I've received, but that’s not information you’ll read ordinarily when you check.

Our biggest problem again, so we do have problems, serious problems, but not a collapse. Our biggest problem is again the way issues are reported to the public, the communication. Chief Justice, I just want to bring to the attention of the Commission
this, patients on death row, that headline is scary, very scary, if you say a patient is put on death row, California’s lack or ventilators means staff have to pick who will leave. You know, they are defining a gory story of how doctors must decide which patient must live and which patients must die, that’s why say they are on death row, because California has got only one or two ventilators and one oxygen point and two men who came there bleeding and turning purple. When you bleed you don't turn purple, actually, you turn pale, but the story says you turn purple, could not be put on a ventilator. This is a shocking story. I was very angry, and they’re quoting a professor here. This professor said this thing happened in 1991. This is a story that happened in 1991 in California. She said, that’s what I was telling this journalist, that we had two ventilators in 1991, we have got thirty-five now, we had one oxygen point in 1991, we have got sixteen now. These two patients who came, the professor said they were not bleeding, they had taken an overdose, they were turning blue and they arrived in 1991, and we had only one ventilator left. That is the story, but this story is written in the present, that the healthcare system is collapsing now.

This one, even more shocking, newborns in danger. It gives the public a feeling of fear. If you read the caption there, that photo is supposed to be of a baby who was not given BCG vaccine because the drug stock out and that baby must not go to the clinic, must not go to church, must not be in touch with people, because the World Health
Organisation says BCG vaccine must be given within forty-eight hours. That is not true, there is nothing like that. We give BCG when children are born just for convenience, but the story here is that we fail to give BCG and this mother ...

When the population read these stories they get very scared. The story was written just after we have solved this problem. The hospital I am mentioning here had six thousand doses of BCG.

So I'm just trying to show that while we have got problems we do have serious problems, like a province like Free State, our problems are big in health and I've confronted the Premier and I'm making an appointment to meet him, because that situation is unacceptable, but it’s aggravated by the manner in which, in other words, South Africa is sort of celebrating that their healthcare system is not doing very well, and we’re just saying, no, there shouldn’t be any celebration, we must work together to solve this problem because many people depend on the system, eighty-four percent of the population.

The other thing I want to bring to your attention is that we did do our own audit, it’s not that we are not accepting that there are problems. We know them because in 2010 we hired those four companies to do an audit of all the three thousand five hundred clinics. They were auditing things like infrastructure, financial management, drug
stock outs, waiting times, attitude of staff to patients, infection control, we have got the results. After seeing those results we said, what then, and we were putting measures. That’s why we came across an ideal clinic. Here were just defining that an ideal clinic is a clinic that opens on time, where there’s access, I don't want to read that, but the Commission can go and study it. I want to show that the problems we are having, we have outlined all the problems in the private sector, now the problems in the public sector can be summaries in four, I call them the Big Four. If we can solve this Big Four, then most of the problems that people are saying are collapsing the public sector will be solved.

The first one is human resources. I've already shown you how ARUAPS is affecting our human resources, how eighty percent of the specialists are in the private sector, I won't repeat it there, but our biggest problem in the public sector are wrong appointments that some of our province do, and I'm not going to hide it here. There are appointments that are terrible, hiring people who have got no idea what they are doing. You are aware that the Department of Health, and I was asking someone the other day why they allowed it, could hire anybody to be a CEO of a hospital even when they have got no idea what a hospital is all about, and I asked them, teachers will never allow that, they will never allow a principal who is not a teacher, they will fight, but in
health it was allowed, and wrong appointments are being made. The whole planning development and management of health is problem.

The second done is financial management, where a province just dismally fails to manage finances, and if they fail to manage finances, they can't manage services.

The third one which is big is procurement and supply chain problem pertaining to stock management of pharmaceuticals, consumer pools, equipment and devices, it's a big problem in the public sector, and delayed payment of suppliers sometimes with consequence to delay of delivery. I don't have time to give you all the steps you are taking, I just wanted to flag the problem, but we are taking steps about this issue.

Lastly, infrastructure and maintenance repair. I call this the Big Four, Chief Justice, because Harvard University have got leadership lectures for ministers in Africa, in the Far East, and Latin American countries, and they last year when we went to Harvard, they had established a Harvard global health system unit, that unit has been assessing healthcare systems in Africa, in South East Asia, and Latin America, and there findings were that the common feature among countries where the healthcare system is not doing well is HR, procurement, supply chain. I'm mentioning this because it has got an uncanny resemblance to what we found in our country, human resources, financial
management, procurement and supply, and then infrastructure maintenance and repair.

Then Harvard says, no, it’s human resources, procurement, supply chain.

So we are looking closely at how these issues are resolved, and we regard our relationship with the private sector such that we can't solve these problems if one is pulling this way and one is pulling the other way.

Now our solutions ...

**JUSTICE NGCOBO** May I ask this, Minister, what about the problem of, is there a problem relating to the quality of service that’s offered to the patient in the public sector?

**MINISTER MOTSOALEDI** Oh, yes, I've already said so. In the National Development Plan, Chief Justice, they said we must solve two problems, one is the quality of services in the public sector, it says so, and two, the exorbitant cost in the private sector, and we accept that, that’s a good characterisation of our situation. So what I was doing here is to demonstrate what is contributing to that poor quality. If we solve these four issues of human resources, financial management, procurement and supply chain and infrastructure maintenance and repair, the quality will improve. So this is a measure of quality, and I was saying Harvard University did the same study.
**JUSTICE NGCOBO** Is there a method of assessing the quality of service that’s offered to the patient?

**MINISTER MOTSOALEDI** Yes, yes, yes, oh, yes, definitely. Definitely. The Office of Health Standard Compliance was established for that reason. When they go they measure lots of things, they measure the clinical care, they measure the management, they measure the drugs stock outs, medicines. Basically we have got an office established for that purpose. We copied that system from Britain, they call it a quality care commission, we call it Office of Health Standard Compliance.

**JUSTICE NGCOBO** Okay, and are the reports of that office publicly available?

**MINISTER MOTSOALEDI** Yes, definitely they will, it’s just that they are still starting, but in terms of the Act, Chief Justice, once they’ve examined, by the way they must also examine private hospitals, even ...

**MS MATSOSO** Inspect.

**MINISTER MOTSOALEDI** Inspect, sorry, they must also inspect private hospital even though they are refusing.

**JUSTICE NGCOBO** So they’ve just started.
MINISTER MOTSOALEDI They’ve just started their work and in terms of the Act, once they’ve inspected a facility they must grade it from A to F, grade A, grade B, grade C, grade F, and the hospital committee and the management of that hospital must call a public meeting to announce the results and discuss the problems.

JUSTICE NGCOBO When did they start? How long ago?

MINISTER MOTSOALEDI They’ve already done a lot of morgue inspections all over because they have sent people to England to train as inspectors. It’s an office that is new. It’s actually still establishing itself fully. The DG here will come and explain about the regulations. At the moment there are problems, I mean, not problems, there are issues about regulations that we are still dealing with.

JUSTICE NGCOBO And then prior to the establishment of that office was there any assessment of the quality of healthcare services in the public sector?

MINISTER MOTSOALEDI Yes, every department has got a quality control. What do they call it?

MS MATSOSO Quality assurance.

MINISTER MOTSOALEDI Quality assurance unit.
JUSTICE NGCOBO  Is that the [indistinct] 9.19.00 that's going to be dealt with by the Director-General?

MINISTER MOTSOALEDI  She said she will address it. There is that quality assurance but it was a unit within the Department. This one is an independent structure. I had the private hospital here, emphasising that if there’s an independent structure they will follow it, but when this structure wrote them a letter, they actually responded negatively, and we have got the [KPs] of these letters which were written a few days ago.

I think I need to go over to the finish. Now, Chief Justice, the World Health Organisation said there are three things which, if they are found within your system, you are not going to make inroads in health, three, three features of healthcare. The first one is hospicentrism, a healthcare model that is around the hospital only, which is largely curative. They said if you find that model in your healthcare system, you’re not going to do well. The second one is fragmentation. I was very happy that the private hospitals here talked about fragmentation because we have been singing that song, we don't want that fragmentation, which we are fourteen departments of health, but again, because of dissociation they don't regard private public as fragmentation, but it is. The third one, uncontrolled commercialism. These issues were mentioned by the World
Health Organisation just like when Dr Margaret Chan, the Director-General, was saying there are seven structural problems of health. In South Africa unfortunately we have got all these three features. We have got a healthcare system that is hospicentric, that's why GPs may not even do simple procedures, they have to admit, that’s why so many people are admitted, we have got a system that is fragmented into costly healthcare for the rich and second rate care for the poor. We have got a system that has largely followed uncontrolled commercialism of healthcare. We need to deal with these issues because the constitutional right to healthcare services, that’s a basic right, it’s in conflict with this whole issue of uncontrolled commercialism. We are also showing if we do not stop or do something, if you look at that graph, it is showing the cost of healthcare, how fast it is growing. At this rate, at this rate, by 2025 private healthcare will be costing R514 billion. This matter is not brought to the attention of the population, the rate at which private healthcare, the story that is being sung is about what NHI wants to do. That table from Treasury, we just cut that part, it’s a whole big table from treasury, you can obtain it from the white paper, which is showing exactly the rate at which that issue is growing. Now, uncontrolled commercialism, based on our observations, some so called analysts or experts are preaching that NHI will be unaffordable because they’re basing their model on this. They actually believe NHI is going to follow this graph of uncontrolled commercialism. We can't allow that. This is
unaffordable. No country can afford this, and that’s why we are going to reach a dead end. So we cannot put up an NHI system that is going to be so expensive, and people believe, no, we are hiding the fact that there will serious expenses. There will be serious expenses if you follow the present model of uncontrolled commercialism.

So what is actually our solution? The solution, as far as you are concerned, is the pooling of funds into one single fund to enable access to good quality affordable health for the entire population, not for a select group of people, and such a system must be dictated to by the health needs of the population and not by uncontrolled commercialism as it is at the present moment. It must not be commercial considerations only that determine what health a person must do. Within such a system there needs to be a massive reorganisation of the healthcare, massive reorganisation to take the public health away from the vagaries of the problems that I've shown you, the Big Four. Also, as mentioned in paragraph 2 and chapter 6 of the white paper, you need to massively reorganise the healthcare system, both public and private. Such a system, it’s heartbeat must be primary healthcare. That means it must be based on promotion of health and prevention of diseases, that’s number one, and number two, the entry to such a system must be through primary healthcare level with upward referral, with GPs, general practitioners and primary healthcare practitioners, and primary healthcare facilities being gate keepers. We need gate keepers in this system,
and that gate keeping must be done by GPs and primary healthcare practitioners at that level. If we don't do that, we are of course going to run an extremely expensive system, and we believe intervention in the market through regulation is justified, when the absence of regulation results in the market failing, we have already said so, but additionally where market fails to achieve outcomes in line with social justice, interventions might be justified, and again, there’s an issue of section 27 of the Constitution. We are just showing, and you asked the question this morning, international approach to supply side regulation, the issue that was said here that, no, regulation must be the last resort, many, many highly developed countries are doing this regulation, as you can see there.

Now, this is my summary, that we need to move towards a fairer more efficient health system for all South Africans, all, not sections of South Africans, based on the values of justice, based on the values of fairness and social solidarity.

I will give the DG to explain the issues about regulation. Thank you.

Oh, it’s not on the slides, she’s just going to talk.

JUSTICE NGCOBO  How much time do you need to make your presentation? I'm just trying to find out whether it will be convenient to break to take a short break now
or whether we should take a short break at about eight o’clock.

**MS MATSOSO** Perhaps we can take a break. I’ll suggest that we take a break.

**JUSTICE NGCOBO** Okay, very well. Can we then take a break for fifteen minutes and come back at about quarter past six? Thank you.
Session 4

JUSTICE NGCOBO  I think from the look of things your team has abandoned you. Are you ready to start?

MS MATSOSO  Yes.

JUSTICE NGCOBO  Or do you want to wait for your team members?

MS MATSOSO  Well, I thought they would be here by now, but I could start, seeing that you’ve been here longer.

JUSTICE NGCOBO  Yes. I see them, they are coming back. Is the Director-General ready to proceed?

MS MATSOSO  Yes, thank you.

JUSTICE NGCOBO  Yes, please, go ahead.

MS MATSOSO  Thank you. I will just briefly share some of the legislative reforms that we’ve engaged in but also identify gaps that have been reported by the Law Reform Commission, because we’ve been doing some work with the Law Reform Commission.
Firstly, just with the legislative reform, and this is, in a way, in response to the question that was raised about quality. We’ve had three major legislative reforms recently, and the first over this period, I think going as far back as 2008, the first was the amendment to the Medicines and Related Substances Act which establishes the South African Health Products Regulatory Authorities.

The second was the amendment of the National Health Act to establish the Office of Health Standard Compliance. One of the things that we have recognised was the concerns about quality, and to find some enforcement mechanisms by which there can be compliance in both the public and the private sector. The amendments were effected in 2012 and they affected mainly sections 77 to 87 of the Act and they established the Office of Health Standard Compliance, which is a regulatory body, and what is good, for the first time we have a body that can impose sanctions, sanctions on CEOs of hospitals or heads of departments, and impose fines, issue warning letters, and come up with other enforcement measures. It’s for the first time that we’ve had this, even though we could have learned from the UK experience of the Care Quality Commission. The Care Quality Commission experience was actually based on the Bristol Infirmary deaths of babies, but they did not create the mechanisms that we have put in place, particularly those of linking the nature of the offences with fines and the severity of the problem. Because it’s still in its infancy, we are hoping that the capacity
will exist for the office to not only enforce but also to serve as a quality system for the country for the whole of the health system in preparation for the implementation of the National Health Insurance because in the white paper we make reference to a requirement that before any institution or before any health establishment or a practitioner can be considered to render services in terms of the National Health Insurance, they have to be certified, that they meet standards that are set by the Office of Health Standards Compliance, so it goes beyond just enforcement but also to impose quality measures.

The third of these is the Mental Health Act and I would like to, I am raising this because there is a much broader legislative reform that is needed beyond the piecemeal approaches that we followed in South Africa. We have two draft bills that have been sent out for public comment. I am mentioning these because they bear relevance to the manner in which we would like to reorganise the way health is delivered in the country. The one is our National Health Laboratory Services Act, it needs to be amended to allow for the creation of the National Public Health Institute of South Africa. The reason we need such an institute is precisely because we have seen an emergence of outbreaks like Ebola, Zika, and so on. So you need an institution that can respond, that can ensure that there’s epidemic preparedness response, but also because diseases,
viruses know no borders. We need to have abilities and core capacities, as a country, to implement the international health regulations which I will refer to also later.

Since 2010, I went as far back as 2010, I didn’t go beyond, and maybe my bias is during my term in my current appointment as the Director-General, since 2010 we have promulgated about a hundred and eighteen regulations. Of these twenty-three of those are in terms of the National Health Act. The others are with regard to different pieces of legislation. In relation to this we also have about thirty-eight regulations that are out for public comment and we've in this period published about a hundred and twenty-six policies and guidelines, and we can share those with you.

I wanted to just share with you what has come out of the report of the Law Reform Commission, it has just been released and shared with us. We were in discussion with the Department of Justice and Corrections to specifically look at how we are going to address these gaps.

So the Law Reform Commission has actually reviewed about a hundred and eight pieces of legislation that are administered by Health, and these date back, as far back as 1919, when the first Public Health Act was established at the time when we had the Spanish virus outbreak, at the time, and I could actually draw a parallel between that outbreak and what we are seeing today with Ebola and other related epidemic
outbreaks. What is, of note in this report is that we’ve got a lot of obsolete and redundant legislation and, for instance, this 1919 legislation, there are certain sections that we never repealed as far back as that, and we still have other provisions that are no longer useful, that are also inconsistent with the Constitution and how it specifically referred to not only the Constitution but also the PFMA, and I’ll cite those few.

If you look, there are also other similar provisions, and these are 1935, 46 and so on, so our concern is that we’ve got all these pieces of legislation, where they were supposed to have been repeals and they never happened. We’ve got also, in the National Health Act, Act 63 of 1977 actually assigned provinces to have certain powers through a proclamation which was passed in 1994. So in that process what did not happen is that as the National Health Act came into force the provinces were also supposed to have repealed the old ordinances. I mean there’s still provisions in provinces that make references to ordinances, there are also provisions that still mention TBV, the old homeland, and so on, they are still not repealed. So it’s sort of that kind of alignment.

When we looked at the repeals, particularly the International Health Regulations because they’ve been amended in 2005, we have not repealed them in our own Act and we have to ensure that we are compliant with international instruments as well. So we have started this process, and I think it was quite useful that we have this report of the Law Reform Commission, and we’ve set up a team between ourselves, the Department
of Justice to specifically look at all the provisions that, because only four provinces actually have come up with a legislation at provincial level, the other five haven’t come up with any form of legislation. So we have to bring about alignment where we have the National Health Act as a guiding act and then ensure that there is alignment for the four, but also come up with other pieces of legislation.

So we have two specific areas where we have not, in fact let me say three, where we have not passed regulations, and this has to do with the provisions that deal with the Human Resource for Health, and specifically because increasingly there is a problem with just drafting regulations, just to tick a box. Our approach particularly with regard to Human Resource for Health is that we have looked at the resolutions that the World Health Organisation has passed, and the manner in which South Africa can comply and implement those, because these are, as a member state, we have obligations to report on how we are doing on Human Resource for Health. So we started by first publishing the Human Resource for Health strategy which has themes, and eight particular priority areas that we needed to focus on, firstly, on leadership and governance, because we pick up that these are specific areas that need to be improved. We looked at how we can revitalise our training platform, not only from a perspective of numbers, but also the institutional capacity, a partnership between ourselves and Department of Higher
Education, but also compliance with the new National Qualification Framework that has been established.

So we have looked at different pieces of legislation, the Nursing Act, the Health Professions Act, the Pharmacy Act, and so on. If you look at how they were formulated over a certain number of years, they don’t take into account the provisions of the National Qualifications Framework, and neither are they aligned to a newer language, and from the Law Reform Commission, it’s quite clear that we need amendment of those pieces of legislation, but we also have to ensure that we can make provisions for standards in the manner in which our doctors, nurses and so on are trained, but also prepare the training platform. Parallel to that, as we were looking at the review, we were also looking at our tertiary services platform. We have just released a report on how we are going to reorganise our tertiary services training platform to prepare both for the clinical training of nurses, of doctors and other related carders.

What is significant about this report is that it also recognises that it’s not just about training, it’s how you fund training. We have to review our funding flows as well as our grunting mechanisms so that we reorganise the way funding is organised.
From a normative approach we’re actually working with WHO developed tools, Weizen tool and we’re coming up with some matrices that can be the basis on which we plan for human resources in the health sector.

That was why I said we didn’t want to start with regulations. We came up with these normative tools specifically, because our view is that you come up with a strategy, you develop norms and standards and out of those you develop guidance documents, and those we have developed, and it’s on those grounds that will then come up with the regulation. So we’ve been sort of systematic in approach and specifically for human resources

The second area is there because the services are being redefined, primary health care, for instance, has been an area of focus. We have to look at the middle level type of workforce that we need so that we can then say which particular institutions should provide training and how these should be regulated, in particular, the community health workers, the clinical, the other [carders]. So we’ve come up with those categories.

We’ve also looked at the training platform and we’ve just finished a business case, particularly for the Ward Based Primary Healthcare Outreach as to how much really will it cost, not just for training, but for future for employment and for absorption into the public service. We cannot do that independent of the Department of Higher
Education and Training, so we’ve signed and will use between ourselves and Department of Higher Education and Training, and we started a project with the health faculties by which we had requested the deans to increase the workforce, particularly to recruit those young graduates who come from previously disadvantaged communities, rural areas, in particular so that they can go back and serve in those communities.

So in this MOU we’ve been tracking the numbers as to how well these students are doing, and we made a little bit of investment because we did not just pay for the fees in a form of a bursary scheme, we’ve also added additional money so that there can be mentoring and support for these young ones. So the numbers for the moment, we haven’t as yet seen the graduates from that programme but the numbers have been quite reasonable.

I wanted to use this opportunity to say that I will probably present a totally different narrative in that the Minister also created what we call a fund, a Public Health Enhancement Fund, which is a fund created by the private sector, and they use the fund to pay for medical students for training of their CEOs, as well as the CEOs, training of medical students, as well as the PhDs, students who want to do their PhD, and we’ve now reported quite a few.
The next point I wanted to raise is that as part of this we’ve done sort of a competency assessment of all the CEOs in the hospitals as well as district managers. To just understand what kind of skills are needed, and it’s the basis on which we, I think recently the Minister in the National Health Council has approved that we create an academy which will be where we will be training, anybody who wants to be a CEO in the public sector must go through that academy, which will accredit, that will be the basis accreditation of courses that are provided for CEO so that we don’t just have a generic training program for all managers. We are also mindful of the quality of professionals that are produced, as well as the quality of professional care, which was raised earlier. I know I confined myself to the Office of Health Standard Compliance but they also statutory bodies that have a role and responsibility actually to oversee the quality of training, but also the professionals that are trained in South Africa, and these are all our statutory bodies.

To try and address some of the problems that we’ve seen lately, the provisions of the National Health Act are such that we need a forum of statutory councils to be established. Just studying those, it’s clear that it was intended to improve governance within these statutory bodies and have a monitoring system about their performance. So this forum has been established. They meet, the forum is checked by the Deputy
Minister, and we have a reporting mechanism by which we measure their performance. The lead person is Doctor Pillay.

**JUSTICE NGCOBO** How long ago was this forum established?

**MS MATSOSO** After the provision of the Act was proclaimed. Remember, we had the proclamation of the National Health Act. After it was passed in 2004 it wasn’t fully proclaimed, so we looked at all those sections where there were gaps, and in 2012 we asked for the proclamation, and it’s one of those that came into force, and since 2012, I think, since then we’ve had regular meetings where I think all the seven statutory bodies meet, the CEOs or registrars, as well as the president and chairs.

**JUSTICE NGCOBO** Yes, I understand.

**MS MATSOSO** Thank you, the other area that is important is that about information. It’s probably one area that affects performance, but we can’t measure our performance if you don’t have information. We do have provisions actually in the National Health Act. The particular section is section 74 that says we must have a national health information system.

In an attempt to implement that we passed two strategies, the E-Health strategy and the M-Health strategy. At the time when this Act was written I guess we did not have
mobile technology as a way of service delivery, like the Minister made reference to MomConnect and so on. Our view is that those kinds of systems that are used in service delivery, we need to come up with some norm setting of some sort, of both electronic information systems, whether mobile or otherwise, and these strategies are available.

We’ve gone beyond that. We have assessed systems, both in the public and private sector so that we can come up with norms that must be complied with by both the public and private sector on whether those systems are interoperable, whether they provide adequate security, and so on. We have used those norms to assess the systems, both in the public sector, actually at primary care level, we haven’t started at hospital level, and we haven’t even started in the private sector.

We have also, and I thought I would address the last part that has been a subject of controversy, and this is on the certificate of need. Chief Justice, you will probably be aware that there are certain sections of this Act that did not come into force, these are in chapter 10.

During the formulation of these provisions, they were controversial at the time and they still are. There’s a general feeling that provisions in this Act that deals with certificate of need are unconstitutional, and we sensed that even during the time that we had...
public consultations with different stakeholders. It’s a matter that we think is probably an interpretation problem. We have asked the Department of Justice and the state law advised us to guide us to assess the constitutionality of these provisions. What is important, what we think is of importance with these provisions is that they actually identify vulnerable groups, and there is those that must be targeted in the provision of services, and even in the identification of the licensing providers. We are of the view that it will increase the number of service delivery points and also it will expand health services if these were to be followed. It will also help to make services more equitable through a mix of both public and private providers. We are persuaded that the manner in which the private providers will render services will have to be guided by the manner in which we formulate regulations. So in preparation for that, what we did, and we are following the same pattern as we did for human resources where we start by, we run a pilot, we build systems, and based on that we, meaning we prepare ground, because we don’t want to write regulations and only start then or maybe a couple of years later nothing has happened. So we’ve actually mapped every single provider in South Africa in the private sector. We know exactly where they are, we know them by name, address. We also want to match that against the socio-economic indicators, the demographics, as well as the other access dimensions, and I’m saying access dimensions precisely because we define access from four perspectives; one it’s about
therapeutic access, financial access, physical access as well as quality as a measure of access, so in coming up with those measures we would like to see how best people access services, particularly the vulnerable groups that are referred to in the National Health Act. We are hoping that that can be the basis on which we engage.

We were quite enthusiastic, I must say, in advising both the Minister and President that these sections must be proclaimed because they had been lying dormant for years. That happened, of course, without regulations and we had to get a court order for that proclamation to be withdrawn, but that did not persuade us from stopping the work. Like I say, we are ready to move.

We have also come up with criteria about how the licensing should happen, but, like I said, this cannot happen whilst we still have those areas that the Law Reform Commission has identified as obsolete pieces of legislation that still apply in provinces. We have to fix those so that when the provisions on the certificate of need come in to force, we would have dealt with those.

I thank you.

JUSTICE NGCOBO Now help me understand the position. Sections 36 through 40 of the National Health Act deal with the certificates of need, and the certificate of need
is equivalent to a licence under the old regulation.

**MS MATSOSO** Well I think it goes beyond a licence.

**JUSTICE NGCOBO** Yes, but it is the authority of a facility to conduct the business of a hospital or depending on what the facility does. Is that what it is?

5 **MS MATSOSO** Well it actually says a health establishment and a health establishment goes beyond a hospital.

10 **JUSTICE NGCOBO** Yes.

**MS MATSOSO** It can be a practice, you know a laboratory service, a radiology service.

10 **JUSTICE NGCOBO** But it’s an authority to, amongst other things, hospitals to conduct operations of a hospital.

**MS MATSOSO** Yes, it is, but the difference is that it’s specific in that it prescribes that we should show that there is a public, private partnership.

**JUSTICE NGCOBO** Yes, I understand, but because those provisions have not come into operation, the position is that the matter is now, is at present regulated by regulation 158 which was promulgated under the 1977 Health Act. Is that right?
MS MATSOSO  Yes.

JUSTICE NGCOBO  Okay, which means that different provinces have different criteria that they apply in the granting of the licences.

MS MATSOSO  Yes, and not all of them have those provisions.

JUSTICE NGCOBO  Yes, now, as I understand it the regulations do not set out criteria that is to be followed in determining whether or not to grant a licence.

MS MATSOSO  In terms of the sections, the National Health Act, actually we should stipulate the criteria, actually we have a draft where we had already started.

JUSTICE NGCOBO  No, yes, I understand but the regulations that are presently enforced.

MS MATSOSO  Yes, those are silent and the provinces are supposed to come up with those.

JUSTICE NGCOBO  Yes, now we have been told by the service providers that there are inconsistencies among the provinces as to the criteria that is used, and in some cases the criteria that is used is not known to the service providers.  Are you aware of
that?

**MS MATSOSO** Not in all provinces, some provinces.

**JUSTICE NGCOBO** That’s right, in KwaZulu-Natal, for example, they still rely on the old regulation, the Western Cape has its own regulations, Gauteng drafted its Act but never proceeded with it so it fell back onto the regulation, and other provinces are taking the view that they can amend those regulations. The situation therefore is that the service providers do not know, in some of these provinces, what it is they have to comply with in order to be issued with a licence.

**MS MATSOSO** Yes, I would agree that.

**JUSTICE NGCOBO** As I understand it that situation is going to persist for some time until a decision is made as to whether or not sections 36 through 40 are brought into operation, if they are indeed finally brought into operation.

**MS MATSOSO** Well, from the comments we received from the same service providers, they have come up with suggestions on the provisions that deal with this certificate of need. We have received those comments. Where are, we need to publish the regulations and have the provisions of the Act proclaimed.

**JUSTICE NGCOBO** When is that likely to happen?
**MS MATSOSO** I think, with the permission of the Minister, because I do not want to make those pronouncements, we’ll get guidance from the Minister as to when that can happen, but I think it’s something that is desirable, it should happen.

**JUSTICE NGCOBO** Yes, I am raising this because you made the comment that in your enthusiasm, I think that’s the word you used to make sure the provisions of sections 36 through 40 which have been lying dormant for some time are brought into operation, you requested that they be brought into operation in circumstances where there was no regulatory framework which was essential for the implementation of those provisions. If one accepts that those provisions have been lying dormant for some time and that is since 2003, and given the uncertainty which is presently obtaining in some of these provinces, isn’t there an urgent need to bring about certainty?

**MS MATSOSO** Well, yes, indeed. This is why I say it was with enthusiasm that we went ahead, because we wanted to address this vacuum, and it in this respect that with the draft that you have that will subject them to the, what we call, the socio-economic impact assessment, and have these published, and engage stakeholders. We had already started the consultations, we had set up consultations with different groupings, but we have also gone further to map all of them. This is why I say we are at a stage where all of this work has been done. We have also developed a software that can be
used for them to enrol and register in preparation for this. So all the systems have been put in place so we just have to move with speed.

**JUSTICE NGCOBO** Does that include the systems for setting up all the regulatory bodies under the National Health Act?

**MS MATSOSO** Well, there are provisions that allow the Minister to appoint advisory bodies, and one such advisory body has been established and publish regulations, and this has to do with the National Health Information Systems.

**JUSTICE NGCOBO** But have all the regulatory bodies that are required to be established under the National Health Act been established?

**MS MATSOSO** In terms of the Act, yes.

**JUSTICE NGCOBO** So they are now up and running.

**MS MATSOSO** In fact, the provisions that are outstanding that must be proclaimed is those sections that deal with certificate of need, most of the provisions of the National Health Act have been …

**JUSTICE NGCOBO** I understand, but I mean the bodies such as the Ombuds that are set out here, let me just give them to you if I may, there is the National Consultative
Health Forum. That has been established?

MS MATSOSO In fact, it meets regularly, our meeting for this financial year is on Monday.

JUSTICE NGCOBO Okay, and how long ago was that?

MS MATSOSO No, we meet annually.

JUSTICE NGCOBO No I mean when was it established?

MS MATSOSO It was established a long time ago, when the Act came into force. The National Health Consultative Forum is a forum where we meet annually.

JUSTICE NGCOBO I understand. I just need to get a sense of when it was established.

MS MATSOSO When the Act was proclaimed, in 2005.

JUSTICE NGCOBO Five.

MS MATSOSO Yes.

JUSTICE NGCOBO Then you have the forum of Statutory Health Professional
Council.

**MS MATSOSO** 2012.

**JUSTICE NGCOBO** It was established 2012.

**MS MATSOSO** When the Act, the provisions of the Act came into force it was set up in 2012.

**JUSTICE NGCOBO** Right, and then the National Health Research Ethics Council.

**MS MATSOSO** It has been operational as well. It’s chaired by Professor Mayosi.

**JUSTICE NGCOBO** And then of course, the Office of Health Standards Compliance.

**MS MATSOSO** Yes.

**JUSTICE NGCOBO** When was that established?

**MS MATSOSO** In 2013.

**JUSTICE NGCOBO** 2013, okay and then the Ombuds.

**MS MATSOSO** The Ombuds, the advert went out, we’re busy with the …

**JUSTICE NGCOBO** So it hasn’t been established.
MS MATSOSO  Yes, we’re preparing for the interviews. The Minister will respond.

MINISTER MOTSOALEDI  Yes, we could have established an Ombuds last year, Chief Justice, but in terms of the Act we need to agree on the level of remuneration with the Minister of Finance. I need to write to the Minister of Finance about remuneration, and I did so last year. Unfortunately, I believe the Minister misunderstood it because he said for that type of a job, we need to hire a retired judge, and that was the response, and said, we don’t need this remuneration, and all that. So I did meet the Minister, it was still Minister Nene, I did meet him to explain to him exactly what the Health Ombuds is and why it can’t be appropriate to do what he was asking for. He then said I must write him a letter afresh and explain all those facts, which I did. Unfortunately he left office before he could respond to me.

So I’ve just started discussions with the new Minister. Last week before he left overseas, his office told me that the letter is ready, it’s just for him to sign, but otherwise we have already advertised, there’s already been short listing. We just, immediately we have that letter, then we’ll interview and have a Health Ombuds because we need that person as soon as possible.

JUSTICE NGCOBO  Those statutory bodies that are set out in the Act are quite essential, are they not, in the implementation of the Act? They are also as vital as the
Council of Medical Scheme is to the implementation of the Medical Schemes Act. Now, we were told by the officials of the Council for Medical Schemes they do not have sufficient funding and sufficient resources in order to fully, to effectively and efficiently carry out their duties, and that’s a matter that they’ve been raising each and every financial year, but to no avail.

**DR PILLAY** Yes, Judge, that is true. The Council of Medical Schemes raises its funds through levies. The levies that the Council for Medical Scheme implements each year has to be agreed to between the Minister of Health and the Minister of Finance. Annually they submit a business plan, and based on that they then propose a levy increase. The Department of the Ministry of Finance is quite concerned about the extent to which these levy increases have occurred, and despite their business plan and explanations, the Minister of Finances has reduced over the years the extent to which those increases have been implemented. I should say that the funding industry, the medical schemes have also written to the Ministry of Finance indicating that they felt that the financing of the regulator was excessive in terms of the fees, and one of their arguments which we’ve addressed with the Council for Medical Schemes is the expenditure that the council incurs is a lot in the area of legal challenges, particularly between the council and the medical schemes that it holds to account. So the Ministry of Finance’s view was that the council should attempt to resolve disputes with schemes
without going through the legal process, but have alternative dispute resolution approaches. So the council is trying to implement that so that it will free up some of their funds to do other things that they would like to do, but the Ministry of Finance has to also agree.

**JUSTICE NGCOBO** Now, with regard to these other regulatory bodies that are contemplated in the National Health Act, is there sufficient funding to ensure that these regulatory bodies have sufficient resources in order to carry out their statutory functions efficiently and effectively?

**MS MATSOSO** Yes, we have a standard way of reviewing the annual performance plans that are submitted and interrogate those and we engage. This is not just those that are in terms of the National Health Act, it’s also other pieces of legislation.

**JUSTICE NGCOBO** But what about sufficient resources to enable these statutory bodies to effectively and efficiently carry out their functions?

**MS MATSOSO** Yes, the Office of Health Standard Compliance, I think there is a provision for them to charge fees, but of course the fees have to be regulated so that they are reasonable. The National Health Consultancy Forum is not a sitting body, it’s a forum where we engage with the communities and stakeholders.
JUSTICE NGCOBO  But somebody must take responsibility for managing or running
the affairs of the forum, isn’t that?

MS MATSOSO  Yes, it’s Doctor Anban Pillay, so he has a budget for it.

JUSTICE NGCOBO  I suppose the question really is this, when national legislation
such as the National Health Act is being considered and enacted, is there any
consideration of what it would cost to implement the legislation and also to consider
and have in place the regulatory infrastructure that’s essential to implement the
provisions of the Act so that you don’t have a situation such as the one that we have at
the moment, where you have an act enacted in 2004 and we are now in 2016 and yet
some of its key provisions are yet to come into operation?

MS MATSOSO  Chief Justice, can I just say something and I would like to just refer to
an approach that we’ve recognised.  It is not just about legislation, I think in general
even policies and this is what the National Health Council has approved, it’s standard,
and I may say that with the work that I have done for The World Health Organisation,
having chaired its executive board, and also with the formulation of resolutions, it is
standard that every resolution is costed in terms of its resource requirements so it’s
standard.
So with legislation, with the socio-economic impact analysis that we conduct, it’s not just about the cost, it’s about the impact it will have. So this new process that cabinet has approved of conducting socio-economic impact analysis, it’s a very important exercise. It’s not just for legislation, it’s for relations and it’s also for policy. So we do it for every single policy document, and this is sort of an approach that I think is desirable, we should have been doing it actually from a long time ago, but we’ve gone beyond that. It’s not just that socio-economic impact analysis, it’s not just about costing, it’s preparing ground, because we are saying before you even write regulations, look at what are those systems that must be put in place. We’ve done that for Human Recourse for Health, we’ve done that for the information systems, so this is the approach that we’ve started introducing.

For the Ombuds, I think we are going to do exactly the same thing, and for all these, what we do with Treasury, it’s a requirement actually, you develop what we call a business case and we also develop a business plan, but the business case is to see how much will it cost, will it be affordable, and what is it buying so that we can use that as a basis of doing a proper costing.

The South African Health Product Regulatory Assessment, we started first with the business case before we even wrote legislation to Parliament. So as the law has been
assented to, as we draft the regulations we also say to Treasury, this is how much it will cost to run this institution, but we have gone beyond that to say that before you even do that you need to know where the people who are going to work for this institution are going to come from.

So we have set up what we call an Institute of Regulatory Science. Now, this is going to be the institution that is going to train people who are going to work for the regulatory agents. So we are sort of systematic in approach so that it is not just the law, it’s also the people, the funding, in a much more comprehensive way, so we’ve taken those into account. So we’ve been ...

**JUSTICE NGCOBO** In the Cape the National Health Act, it’s a key statute, because as far as I can recall it is the first statute that’s been enacted in order to give effect to the provisions of Section 27 of the Constitution. Do you know whether that exercise that you’ve just described to us was done in relation to this one, or is what you’ve just described something of a recent occurrence?

**MS MATOSO**

No, I was just going to say that if you look at the document that preceded the formulation of the National Health Act, the policy document, that was about the
restructuring of the National Health System. It was passed in 1996. I don’t think those processes were conceived at the time.

JUSTICE NGCOBO I understand.

MS MATSOSO I was just saying that these are things that you have introduced since the Minister took office.

JUSTICE NGCOBO Just one last question on these regulatory issues. Now, if you take the Medical Schemes Act, you take the National Healthcare Act, and these other statutes which, if you just bear with me, they run up to about fourteen different pieces of legislation. Now, each of these has got regulatory bodies that has been established and some of their functions tend to overlap. Is there a concern, perhaps, that if you have so many regulatory borders with, at times, overlapping functions that might give rise to inefficiency?

MS MATSOSO From the Law Reform Commission report, I think for me, it’s quite a useful exercise because it identifies those kind of problems. Of course, they don’t talk about overlap, but they just look at how we can not only achieve alignment, but rewrite, the general recommendation is that some of the statutes are over forty years, they’ve been in existence for forty years, and some are no longer in fit with the
Constitution or other provisions and their inconsistencies, and so on. So the proposal is that we need to rewrite some of them, and in that exercise I think we can, with this review, do a general consolidation of some of them, it’s quite opportune and I see this law report, the commission report as a very useful exercise that is going to be informative for our processes. We will share the report with yourselves.

**Justice Ngcobo** My colleagues are going to clarify some of the issues that have been raised in the process. We’ll start with Dr Bhengu.

**Dr Bhengu** Thank you Judge. Thanks Minister, DG, DGG and all of the officials of the Department.

I will just pick up on the issue that we were on, flowing from Professor Fonn’s question yesterday, or this morning rather. On Monday, we had, Tuesday, we had the KZN Department of Health, and one of the questions the panel posed to us, exactly on Inkosi Albert Luthuli Hospital, for the same reasons where we were looking at access and interaction between public and the private sector. We’ve heard the Minister address his understanding in the situation of the Lesotho project. Are there any such concerns regarding the model of Albert Luthuli that the Minister would like to comment on?
MINISTER MOTSOALEDI  Absolutely, yes. There are, and in fact the MEC there has asked us many times when is the contract coming to an end. He regards it as a national contract, and every time he runs out of funds, he points a finger in our direction, if he can’t fund all the other activities. We haven’t examined it because it’s a signed contract, but we are putting it in the same category. As I said Dr Bhengu, the SCOPA, SCOPA in parliament, Standing Committee on Public Accounts together with Correctional Services came to cabinet to complain, not specifically about Inkosi Albert Luthuli, but about everything called a PPP in the country. The reason that it was Correctional Services was because there’s a very big Correctional Service facility called Sinthumule Kutama in Vhembe district in Limpopo, and they were complaining specifically about that. Then they said everything you call a PPP, we don’t understand and appreciate why you call it a partnership, because in all of them, the state is losing, the other partners is always gaining, there’s no sharing, and that’s the state that we need to stop all those kind of partnerships.

The Minister of Defence who was there, and the Minister of Correctional Services actually alluded to that fact. He said, I agree with them because we are running this huge Correctional Service facility, it’s run very well and efficiently, but, in her own words she said, it’s a money guzzler. That is what the MEC for Health in KZN is telling us. He’s saying the hospital is run very well, but if you have to do another
hospital like that, then you will close shop, you’ll close all the budget, that's more or less what the Minister of Health in Lesotho is saying.

Then Treasury was asked us to go back to the drawing board, to draw a new PPP, so they didn’t say do away with PPP, cabinet said draw a new PPP which will satisfy the issue of partnership as the standing committee in parliament is saying.

Treasury did go back, but the model that was drawn was for Health, because we are the ones that wanted the PPP’s very urgently, and they said, no, we don’t want one for Health only, it must be for the whole government. Since that time we have not really have had any acceptable model. We’ll also appreciate the fact that COSATU has been challenging this issue, it’s always been threatening, every time there’s something called a PPP, because they regard it as privatisation, but in all truth, the PPPs that exist are not for the state to gain anything, it’s for people to get money from the state in the name of partnership. We don’t have any better one which you can point to and say this one, we have actually benefitted.

I just forgot to mention one, when I was mentioning Lesotho, one of the biggest problems we’ve got in the Free State, and the healthcare system there is going down very fast, there is a PPP with Netcare in Universitas Hospital. It’s terrible when they tell you some of the things that are happening there, because I told you, when I
explained ARUAPS that you actually have doctors who blackmail you and say we’ll go to the private sector if you don’t do A, B, C. Out of fear, the Department of Health in Free State established within a public institution a section must now become private within a public institution funded for by taxpayers’ money, a section and they said doctors, instead of leaving us, instead of going, we are allowing you your private section there, so that you sit in the hospital, see our patients, but you can see your own patients in the private section. In other words, after seeing our patients here, you can see your own patients, which you’re going to charge.

Now, we’ve got such a situation in Universitas Hospital. The patients there were inside the hospital will be regarded as private, and the doctors will be charging them private fees. Meanwhile they’re in an institution which is a government Institution. Now, we had horror reports where they say when they are in the sector that is regarded as public, obviously that is a sector for poor people, let me put it that way, the private one is always for the rich people, when they are there, they said even when a doctor is in theatre having put someone under anaesthesia, doing an operation, if work comes that there’s an emergency in the private sector, that they literally leave a patient under anaesthesia, with nurses, to rush over to that side, because on this side are the poor, and the salary I already there, it’s guaranteed. On that side it depends on your performance because you’re going to be paid individually.
So, this is a very perverse incentives that brings the worst out of human beings and yet they are called PPPs. It is the reason why the legislature in Gauteng cancel an Institution called Folateng which was there in Charlotte Maxeke Academic Hospital. There was something called Folateng there, meaning get well, which was also a private thing. So at the moment we don't have any private public partnership, which we can how to you and smile about and say it’s serving the public, it’s not. There is none.

**DR BHENGU** Thank you Minister. Then the next question relates to the white paper of the NHI, which was released in December 2015, and subsequent to that, the Business Day quotes you on 1st February. It reads thus, “South African Health Minister, Aaron Motsoaledi has distanced himself from a controversial proposal in the white paper on NHI to slash the benefits offered by medical schemes, saying the state should not limit patients’ choices.” Is Minister in a position to just clarify? Because there seems to be a contradiction there, given the role of the medical schemes as envisaged in the white paper and the Minister’s subsequent comments, if what the Business Day says is correct.

**MINISTER MOTSOALEDI** Firstly, there is no way I can distance myself from the White paper, it’s not possible, it’s the interpretation perhaps of the interviewer that there was some distancing. I was having, what I regard, as a discussion to open up
avenues for people to understand. White paper was released for public participation and there was lots of misunderstandings about what’s going to happen. I was just showing all sides of the views of what’s likely to happen, what people can say, because there’s an argument around the country, that, for instance, we can have NHI and have medical schemes at the same time, and the story was not complete, because I said NHI is a fourteen year programme, five years, five years and four years, and I said when the last four years, starts, where we have set up structures, we have set up everything, I wouldn’t understand why medical schemes like Parmed, the one I belong to, GEMS, the one public service belong to, PolMed, the one police belong to, I said I don’t know, I wouldn’t know any justification for them to exist, if the State comes up with NHI, immediately when you arrive at that level, there won’t be any justification that they exist. Then I said the other schemes, maybe there might be a debate by people who believe if NHI is mandatory, they can join NHI and still go to have other private schemes around. That issue in the white paper doesn’t appear like that. The white paper clearly say only supplementary. So I just showing many sides of the debate, that these are the debates that are coming in coming in, they might be put on the table. Unfortunately, it was understood that I am distancing myself. I don’t know how I can distance myself from a document that belongs to the state, which was passed out us, which was passed out by cabinet.
Dr Bhengu But, but to be sure …

Minister Motsoaledi I want to clarify that it was definitely not distancing myself.

Dr Bhengu So to be sure, what is in white paper which is medical schemes will offer supplementary services.

Minister Motsoaledi That’s what we’ve issued to the public, that I what we've issued to the public and say debate it. All I was saying I some might come with a different version and say no, this must not be supplementary. At the moment, what is on the table is that they must offer supplementary services, that is what we’ve offered to the public officially.

Dr Bhengu Thank you very much, Minister, for that clarification. In your presentation you referred to the fact that the HPCSA is empowered in terms of section 53 of the Health Provisions Act, to determine and publish normative fees. This is about the tariff. A week ago or two, we had the Health Professions Council who on questioning made it clear that they did not believe that the Council is neither equipped to publish tariffs or determine tariffs from scratch, nor would it be in its interest to do that, because it would compromise its position when it needs to rule on tariffs, whether
they are unethically high or not. Now, from where I’m sitting, it seems like there is also clarity that’s needed. What is the Department’s position?

**DR PILLAY** I think the principle is that generally professional councils are usually filled with the profession involved in that particular council, and for them to determine their own tariff may be a conflict, so it’s usually useful for an independent party to do that. The understanding was that the ethical tariff with the HPCSA will be the basis on which adjudication would happen, when there’s transgression, when patients complain to the HPCSA that they’ve been overcharged, and the basis on which they make that judgement, needs to be determined.

We had a number of discussions with the HPCSA and had come to an agreement, that an independent structure should establish a tariff, the HPCSA should use that as the basis on which to adjudicate whether there’s excessive charging or not, because clearly the clinicians that sit on the HPCSA have a material interest in wanting to make sure the tariff is as high as possible, and there may have then been accused of a conflict.

**DR BHENGU** Which would mean that the process is not proceeding from where it was around 2012. So until that independent body, if that’s the final solution, is up and running, the gap that exists in the market, will remain for a while.
DR PILLAY  That’s right, yes.

PROF FONN  So, who is going to do what to shorten that period? How is this independent body going to come about and when is it going to come about?

DR PILLAY  Our hope was that this investigation will give us some sense of what should happen in terms of [indistinct].

DR BHENGU  Thank you. I've got two more questions. The one is really just wanting to get a sense from the Department as to how the Risk Equalisation Fund, the position regarding the Risk Equalisation Fund, in the interim, as the planning proceeds, regarding the NHI, for example, what is the stats in terms of that?

MINISTER MOTSOALEDI  Well, Dr Bhengu, we really thought the Risk Equalisation Fund as a diversion and we shelved it because we thought it’s a diversion on the issue of a permanent solution, as in the National Health Insurance, and we shouldn’t really be chasing that type of a solution. To me, I might be wrong, I thought we might have, we might be chasing another PMB which will become a problem later. I said we must just shelve it and concentrate on establishing NHI.

DR BHENGU  I suppose the questions that come immediately is whether the Risk Equalisation Fund, in the short term, does it have to be mutually exclusive from the
NHI when it is ready? Because one is probably looking at a situation where if you’ve got eighty medical schemes, it’s not just eighty risk pools in the private sector, but if you include the benefit options that need to be self sustaining, that you can see that the risk pools are actually even more sort of, there’s even more than the number of schemes. Now, is there a case to say, well while the NHI is being planned for and implemented, is there a case to effectively reduce the risk pools from the eighty schemes to the effect of one, really, on the basis that you are dealing with the variable risk that we know exist in the schemes?

**MINISTER MOTSOALEDI** Well, if you say in the interim, we will look into it, but I was just saying will not very enthusiastically go in that direction, since we started the whole issue of NHI, but will go and look into it, with the proviso that it’s something really in the interim.

**MS MATSOSO**

Maybe, Minister, just to add, if you look at what was published in the white paper, we actually identified six work streams, and one of them is specifically looking at the reform of the medical scheme industry, and we look at all issues related to the medical schemes and it will present an opportunity to look at everything about the medical schemes, and we can share the terms of reference.
DR BHENGU  Thank you very much.

DR PILLAY  I was involved in the Risk Equalisation Fund in its early days.  I think it’s fair to say that the panel’s heard a lot about people who support the Risk Equalisation Fund, but there’s also a significant group who are opposed to the Risk Equalisation Fund.  There was even a point that the Department was told that if you proceed with this, we may challenge it because we are not happy with this policy proposal.  So it’s not as if the whole industry, the funding industry, I mean, are on the same page in terms of this.  I should clarify that.

DR BHENGU  Thank you very much.  I suppose the last is not so much a question, but a statement, really, because there will be opportunities, I think, to explore further as we go on.  I suppose the concern is around the slides that we saw presented today about hospital costs, and if I remember very well, the referenced material is the report of the International Federation of Health Plans.  If this is the same document, we did look at it because, of course, the Department has referred to it a number of times, and we were not quite comfortable that the methodology would stand scrutiny, but that’s not what we are doing now, but I think it’s fair to expect that's the discussion would like to get into at the time that we reach that stage regarding the focused hearings.  Thank you
very much.

DR PILLAY Can I just clarify that one of the difficulties we have is that we have sight of the cost information as it’s available from medical schemes, and as you know the industry argues while, it’s, cost is a function of price and volume, so you don’t have sight of the volume and there is this age factor and burden of disease, I don’t want to repeat what you’ve already heard. So the reality is, well, what’s the issue around price because we don’t have sight of the price as the Department and this is not in the public domain. So I think that while these methodologies may not be used to set a price for a particular service, I think there is a particular trend that it identifies which requires further investigation. So I don’t think we can use these slides to say that this is what the price of an angioplasty must be, etc. we weren’t suggesting that.

DR BHENGU Thank you very much for the context, thank you. Yes, DG.

MS MATSOSO Can I just say that, Minister, and I’m sorry to raise this, there’s also much broader discussions about access to health technologies and affordability, and one of the areas that are currently subject of debate globally is the UN process that has started, like, as we speak, we heard public hearings in the UK, next week we’ll have public hearings in
South Africa, particularly on similar issues, it may not be the cost of services, but in particular it’s products, technology and what mechanisms exist, and with right kind of approach on how we bring a balance, and then policy coherence. So I think it’s an area that would be of interest to the Commission.

DR BHENGU Thank you very much. Thanks, Judge.

PROF FONN Thank you very much for your presentation and the opportunity to have this frank exchange. It really is appreciated.

In multiple different hearings, there were complaints about the efficiency and effectiveness of the Health Professionals Council, of the Nursing Council, and I think to some extent we discussed the CMS, but certainly in relation to the Health Professionals Council and the Nursing Council, do you have influence? I know you’ve done this inquiry in relation to some of the bodies, but do you have influence and do you have any advice for us on how we might think through what interventions are required to improve the effectiveness of these institutions?

MINISTER MOTSOALEDI Well, firstly, it is true the Health Care Profession has lodged lots of complaints about the efficiency of the Health Professions Council. We also picked some of the issues, instead of them dealing with them piecemeal, which I
have been doing for quite some time. I’m sure that the Commission might be aware that we set up a Commission chaired by Professor Bongani Mayosi, and they went very deep. I gave them sixty days to do that work and they came back and said the depth of the problem is such that we won’t finish, they end up doing the work in six months. They’ve come up with recommendations which, we believe, are far reaching. Some were about just gross incompetence of some of the people involved, that’s why they recommended that we take to DC, disciplinary hearing, the three most senior people, in the name of the CEO, the COO, and the legal manager. The present council is doing that. Other recommendations were about the structure itself and there’s a long history there, right from the first time the Health Professions Council came to South Africa. One of the findings is that perhaps the abolition, remember, this was called South African Medical and Dental Council, then of late, after democracy, there was a feeling that we can’t be having doctors alone in one corner, then the Health Professions Council was introduced, the Medical Council just became part of it, but the nurses refused and they kept their Nursing Council, as the pharmacist, [indistinct] the Pharmacy Council, the doctors agreed, the Medical Council became the Health Professions Council, which mean they include other health professionals.

One of the things that is happening, is that one of the groups, for instance, are EMS, Emergency Services, who are ambulance drivers, they actually train for six weeks, but
then sitting in the same structure with somebody who trained for fifteen years, if you regard some specialists a people who have trained for fifteen years and taken those decisions together. So, they said decision making has become very fractious and a battleground, and that EMS is growing a lot faster than any other. I mean the Health Professions Council has how many boards?

**DR PILLAY** Twelve.

**MINISTER MOTSOALEDI** Twelve, one is the Medical and Dental Board which previously was the Medical and Dental Council. Then the other will be the Board for Physiotherapist, then there will be for Psychologist, there will be Optometrists. Now they say sitting together in that structure and taking decisions is becoming extremely difficult, if not impossible. One of the recommendations is that because the Medical and Dental Board is the biggest, it be taken away from the rest and then when we have that old body which was called South African Medical and Dental Council, and the other formed another body, which will be manageable. In other words, they are saying the manageability and conducting of meetings and decisions is very difficult, but, as I said, some of them was just the issue of skills, management skills of that structure, and we are busy dealing with that and I think we will reach resolutions if we implement everything written in that report. For instance, there was a KPMG report into the
Health Professions Council when implemented will have improved some of things. It was simply not implemented. So the recommendation is that it must be listed because it found some of the people inside the management of the Council wanting. The other was that they have discovered that over the years, this I a Health Professions Council, but have discovered they is basically a council of lawyers, unfortunately, in other words, there are more lawyers than health professionals in that Council, and that’s why they are not able to deal with health issues, they are always dealing with legal issues, because most of the people who are there are legal rather than health professionals.

**PROF FONN**  Thanks, Minister. We’ve read the executive summary, so we have had sight of that report. It’s a long standing problem. I trust, I hope that it’s right, that if you simply cut off the head, the body will improve. Just to draw your attention to the fact that we are supposed to work as a health team and that by separating people, we might undermine what has become in fact an international trend of bringing these bodies together, rather than separating them. The separateness doesn’t seem to be an explanation, however, for why the Nursing Council seems to be so ineffective. They are just one group, and it seems that many things have been referred to them and they simply have not replied. We had submission after submission, waiting for information, waiting for feedback and having no response whatsoever. So if we have to think through the way this impacts in the private sector, and clearly it has an impact beyond
that, again, advice for us on how to think through what might improve it would be welcome. You may not have something now, but if you come up with a good idea …

MINISTER MOTSOALEDI  We did have a summit about this. I think the problem of nursing in South Africa must not be confined to the Nursing Council only, it’s huge, it’s much broader than that. So in 2010 we called a special summit. When I was advertising it on TV, I used to call it the CODESA of Nursing, in reference to CODESA that brought back to the new South Africa, because we said we need to bring back a new nursing profession in South Africa. There are huge problems, I won’t go into them because of time. Part of them having started in 1987, three years before democracy, when the whole curriculum of nursing and how nurses must be trained completely changed. We think that structure must actually be re-visited . So I attended five days of that summit and putting my special emphasis all on, because there were seven commissions on the Commissioner Board of Training of Nurses. I became very depressed because there were two many groups there fighting. Part of the problem is nurses that are fighting among themselves, not because they naturally hate each other, but because the changes that happened to nursing in 1987 brought about this scenario, where we have got difficult ... Maybe just in short to describe the scenario, generally nurses were trained by the bedside inside the hospital, there’s a nursing college which is inside the hospital yard and they are next to the bedside. Now, 1987 change was that
they were going directly to university. Most of the nurses who were trained before
1987, for them to get, I’m sure, Chairperson, you will understand the [indistinct] in
nursing, you go to train for three years, you get a maroon epaulet, and then you are
called a nursing sister, then, you go for one year full, you get the green bar, then you’re
called a midwife, then you keep on accumulating bars. That process used to take seven
years. Now in the new curriculum it only takes four years of theory and no practise in
a university. We do have that type of situation which is very problematic. So because
of that, it affected the Nursing Council. One of the recommendations of the summit
was that we must have a person called a chief nursing officer in the Department of
Health who controls the whole fraternity of Nursing. She’s working around the clock,
we’ve got a person who is a chief nursing officer working around the clock to try and
bring these changes, we think, including the curriculum by the way, we have changed,
we are piloting the training of nurses in the old method in three provinces already, in
three colleges, just to pilot and see if we can produce a new type of a nurse. That’s
going to be a process that won't be very short.

**DR PILLAY** Sorry, can I just also say that in terms of the statutory Health Councils, I
heard a number of them suggesting that these structures must be independent of
government, and sometimes there’s a preoccupation that the structures must be
independent of government. So one of things is that independence brings is that its
own decision empowers, and then you get letters to the Minister saying that you must
act against this, but you’ve just removed the Minister’s powers against these Councils
and then you ask the Minister to then intervene on something where you’ve diluted his
powers, so it does become far more difficult for the Minister to do that.

PROF FONN Thanks for that explanation. When we met with the Council of
Medical Schemes, they said of many of the issues that came up systematically have
been dealt with and could be resolved through the Medical Schemes Amendment Act,
and we were wondering where this was and when it might be passed and what the
status of the Amendment Act is.

DR PILLAY So the Medical Schemes Amendment Bill has been prepared, it had to go
through the socio-economic assessment process that DG was explaining, and they have
finalised that. It will then go through cabinet and then parliament will then give an
indication on when they will consider that piece of amendment.

PROF FONN Is that likely to be a six month process, a one year process, a three year
process, do we have any sense?

MS MATSOSO
Well, if I was just to describe the legislative programme, it has become quite elaborate, in that before we even pilot any piece of legislation, we have to conduct the socio-economic impact analysis in advance and take this through the foresight process, which is a forum of a directors-general and it’s only then that it will go to cabinet, before it even goes for public comment. That process alone will probably take us about six months, and looking at the legislative programme and the public comment and participation process, it cannot be less than a year, I would estimate two years.

PROF FONN But we should definitely be taking it into account as we go through making up our own recommendations. I had one last question. I wanted to clarify, Minister, if I understood you correctly, what we’ve been led to believe from many of the submissions that we’ve had so far in many of the hearings, is huge willingness and great anticipation to participate in the processes of the Office of Health Standards. Did I understand you to have said, that you’ve just had recently a letter from one of the hospitals refusing to participate or to follow some instruction in relation to the office?

MINISTER MOTSOALEDI I’m sure it might be my own interpretation, but there are three letters, one written by HASA, the other written by Netcare and the other written by the National Hospital Network. The Office of Health Standard Compliance has reported that patients reported to the office complaining about the quality of care which
they received in some private hospitals, and they wanted the office to investigate. The office wrote to do particular private hospitals requesting information, in other words, to start assessing exactly what the patients are talking about, or whether they must move in. Instead of getting that information, they received letters which you could see are from lawyers, maybe instead of interpret, you can just read them, but basically, they were asking under what powers are you looking for that information, but they are also alleging that you can‘t be threatened in to inspect us when the regulations are not yet enforced, because the issue of regulations, I’m sure DG described where there are, and so they were questioning that issue of regulations. Maybe he must send over the letters to the Commission, then you could see, interpret exactly what it means, but that’s what I was trying to express.

**DR PILLAY** I can give the letters to the technical team, the three letters.

**JUSTICE NGCOBO** Yes, I think it would be helpful if we could have those letters being perhaps handed in as part of the submissions of the Department of Health and perhaps ... How many letters are there, three?

**DR PILLAY** There are three letters, one written by Netcare, one by HASA, and one by other one by the National Hospital Network.
JUSTICE NGCOBO  Perhaps we can mark those letters DOH1, 2 and 3 respectively.

PROF FONN  Thank you, because what it did seem in a lot of the discussions was there was enormous expectation of what this office could and should and might do, and expressed willingness to report information to it, and, I suppose, from the point of view from this particular hearing, some discussion or concern about whether the office was ,if it could and did do all that might if it was sufficiently funded and was sufficiently staffed, and you feel confident that, I heard what you said before, you feel confident that that is the case.

MS MATSOSO

Yes, I think because it’s a newly established [policy], like I said they have their own premises, they have staff trained, but of course they have to expand their capacity so that they can inspect both public and private sector health establishment. The particular issue I was raising is that there’s a provision for them to charge fees and the ability to return those fees so that they can fund their operations. I was mainly referring to this, so that they aren’t just reliant on fiscus.

PROF FONN  Sorry, one sub question under this, I’m definitely stopping after that. Another area that had come up for discussion was around rational use, rational
processes in care and the role of a potential health technology assessment body, or something like NICE in the UK. What is the position of the Department in relation to this, is it something that you are planning?

**MS MATSOSO**

Well, it’s in the white paper but what we started is to have discussions with NICE so that we can start preparing ground. We are in consultation with the University of the Witwatersrand which has started similar work, but of course it will be some form of partnership with various institutions. So we’ve started that work, and we will be convening different experts in preparation for the white paper once it’s policy. Like I said earlier, the approach that we follow is that we start putting in place building blocks, creating institutions, providing training, because what we’ve picked up is that in some of the regulations sometimes people are not sufficiently trained and we don’t have adequate capacity, so we start those processes well in advance, before a policy is finalised and before regulations are published. So that process has begun.

**DR VON GENT** So this kind of body is envisaged as one of the building blocks of the NHI and does coding fit into that process in any way?

**MS MATSOSO**
We’ve been doing pilots in some of our hospitals for the DRGs and we’ve also finished work in doing the DRGs and ICD10, and we are looking at whether we need to move beyond that, because some of the countries of course are way ahead, but we want to do it systematically. The coding process of course will also be linked to some of the institutions. If you’ve read the white paper, we’ve actually identified what kind of institutions needs to be created under NHI, and for some of those there’s the Commission, there’s the advisory body and there’s also the health technology assessment body, like NICE that we’ve identified. I think there are a few institutions that we’ve identified under NHI.

PROF FONN  In the creation of this, are you assuming that it’s a unitary system, so that the coding or NICE or whatever it would be, would include both the public and private sector?

MS MATSOSO  

Yes, we will and perhaps maybe just to say that globally the discussions about how different not only at country level, even some of the global bodies can engage and involve non state actors in a manner that helps us to manage potential risks. So, these will be the basis on which the World Health Assembly will approve these, and I think they will serve as guidance to countries on how the public/private sector and also civil
society and academic institutions and philanthropists on how they should get into partnerships and how they should work. I think it will serve as a model and a guidance to countries on these kinds of behaviours of different actors.

**PROF FONN**  Thank you very much. Thank you, Judge.

**JUSTICE NGCOBO**  Can I just make a follow up on this last question? The relationship between public and private, how confident are you that the relationship will, well, let me ask you this question differently, are you confident, Minister, that the relationship between private, well, the private and public relationship will work out?

**MINISTER MOTSOALEDI**  I think it depends on the issues. It depends on the issues. Obviously the area where you could see this clear difference of conflict is on this issue of pricing. This is very obvious to everybody, but on all the other issues, it can work. The DG here just gave an example, maybe let me explain. When I did realise that there was a conflict, especially when we started discussing NHI, every time, this NHI is going to cause problems, it will destroy the economy, etc. So I did meet CEOs, sixteen CEOs of private companies, that means hospitals, pharmaceutical companies, etc. and asked them whether our relationship should always be this confrontational or antagonistic relationship. I said surely there are certain things which can bring us together because we are in one country, we’re sharing lots of things. There are certain
things that we can work together on, and then I suggested to them, I said number one, you can help us fight HIV and Aids, we can work together on the fight against HIV and Aids, both public and private. Number two, the issue of human resources, the human capital of the country. I said we both depend on the same human capital of the country. We can work together to raise that human capital and build it together rather than being antagonistic. They did agree on that particular one. That is why we lodged this what they call Public Health Enhancement Fund with the DG [indistinct 1.36] and they started contributing money to that fund. The last time I checked the total contribution was 40 million. With that money we paid for extra medical students. In other words, we asked universities to take extra students which they will not have taken before and we will pay. Wits University was the first one to do so and we paid from that fund. The second amount of money was to train CEOs. We have already had one initial training of a hundred newly appointed CEOs. The third amount we said, can we produce one thousand PhDs in this country in health over the next ten years, can we show the nation one thousand people who have got a PhD degree, who have being trained by us over a period of ten years? And we established that when DG said we have already recruited. We started, is it 2013 or 2014? Yes, we started, and most of them, I am happy because most of them are women who are doing PhD and being paid for this fund. When I spoke to some of the women why they seem to be preferring that
rather than other scholarships, they said this one allows them liberty as women to be able to raise families while they are studying and working at the same time and they said it is the best form of an investment. So we are going on with it. I don’t know how many have already qualified at the moment but our target is one thousand in the next ten years. So that we are doing in the private sector. We are not really enemies, and then I went to them recently to say we can extend that to regulation. Most pharmaceutical companies will angrily really say the Medicine Control Council is very slow, it has got no capacity. We have now abolished it, we are re-establishing SAHPRA, South African Health Products Authority. I said you can also help to find people in regulatory medicine in those fields even to go overseas and come back with degrees and skills. So on those scores we are cooperating. The problem, Chief Justice, comes when you talk pricing and regulation. Then that is where the problem starts.

**JUSTICE NGCOBO** But the Act empowers the Minister to ask for this information, make regulations to make sure that this information is given. I am just looking at section 47, for example, evaluating services of health establishment. All health establishments must comply with the quality requirements and standard prescribed by the Minister for consultation with the office, this is the Office of Standards and Compliance. Then it goes on to say, the quality requirements and standard contemplated may relate to human resources, health technology, equipment, hygiene,
the delivery of health services, business practices, safety and the manner in which the
users are accommodated and treated. So you have got the power.

**MINISTER MOTSOALEDI** Let’s appreciate that advice, Chief Justice. Very much
appreciated.

**JUSTICE NGCOBO** But it’s the regulations that must be in place for this to happen.

**MINISTER MOTSOALEDI** That’s why I am saying we appreciating the advice. I
though what the DG was doing was trying to outline since 2013, maybe let me accept
this, Chief Justice, which might not be clearly known to the public. You see, there was
a decade when The Department of Health in this country was dysfunctional, I must
confess to that, there was a decade and I have said that in many other forums, that’s
why maybe I shouldn’t be afraid to say it here. Many people know the problems in the
Department of Health brought by Aids denialism and they believe that was the only
problem. There was a lot of **tearing apart** in department where it was not agreed with
professionals, lots of people were leaving, running away, including the DG here. She
used to be a worker in the Department of Health, she ran away to work for the World
Health Organisation, as many others because of this conflict. So that department was
left very empty, I must state, and so empty was it with skill or with health
professionals, everybody was washing their hands off, so empty was it that we got an
international company, McKenzie International to come and investigate the department in terms of management and everything. They spent eighteen months. The report they gave was not nice. They said they have done six hundred organisations and governments and NDTs worldwide, and the Department of Health in South Africa it is number three from the bottom. That is the report. I took that report, I showed it to the President and the deputy then and I said I need to work on this. So we had to work on building a new management in the Department. If you check, most of the new managers start with the DG had to become new because we had to deal with that report, and now during that period lots of things were not happening. That explains why the National Health Act was passed in 2003, but nine months later when you came in, new regulations. So she started from the scratch to put them. There was a lacuna, a dysfunctionality during that particular period, that’s why even the statutory bodies became very weak because they had no supervision. I think that period must be very much appreciated by South Africans. So it explains why you will pass an act for nine years, now the act is being, provision of the acts are implemented. So we appreciate that, we look at it, only that we were taking what we thought was urgent, then do what was urgent then and I can say maybe we’re just running behind schedule.

JUSTICE NGCOBO Thank you, Minister, for being so candid.
Thank you, Minister, and Director General and your colleagues for your presence and your presentation. My first question is with regards to the prescribed minimum benefits. My understanding is that the Minister is empowered by the Medical Schemes Act to review the PMBs, and I would like to know if this has been done and what were the findings, and if not, why.

Yes, the PMB legislation indicates that the department must review the PMBs every two years in consultation with the Council. The PMB legislation raises a number of issues, and I think the Minister spoke about some of them but just to recap. The first is that the way the PMB legislation has been implemented has largely been hospicentric, and the PMB legislation was implemented at a time when out of hospital care was affordable. I think the intention was that if people even self funded or partly funded the out of hospital care, healthcare would not be, the cost of healthcare would not be as high as what it is now for households.

So the list of conditions within the PMBs have clearly been a list that needed to be expanded because, as the Minister indicated, we keep getting requests about why this condition is on, why that’s off, and, remember the PMB list was developed through a process linked to the Oregon experiment type approach. So additional to that was the fact that the cost of healthcare in South Africa is going up, as we have indicated, and so
the question was if you are going to add on more conditions into the PMBs, you're basically making medical schemes more and more unaffordable for the ordinary man in the street. Is the approach not to first review what is driving these costs before you add on more PMBs, because you can add more PMBs but the point is that then the medical scheme premiums will go to a point where it will become extremely unaffordable for the average South Africans currently. Medical schemes would argue they can’t provide primary care benefits because they have to fund the PMBs. So the reality is that until we deal with the issue about costs and prices, reviewing the PMBs is just going to force South Africans to get into a situation where it is unaffordable.

DR NKONKI  I noted on slide 61, the medical schemes task team had recommended that the PMBs could include, have a primary care focus and in all the submissions that even you have highlighted, that they were largely hospicentric, and why was there such a departure?

DR PILLAY  Unfortunately I wasn’t there at the time in 1997 when this task team made its recommendation, but the task team recommendation was that primary care and chronic diseases and psychiatry, etc. must be provided by the state from using tax revenue and that these five hundred and ninety diagnostic treatment pairs are then allocated into under the PMB banner, as such. I think from my discussion with those
that were involved with the process, was at the time it was quite affordable to do that, but what happened in 1997, and if you see the history of the costs, you can see they had never predicted at the time that PMBs will cost what they cost now, and so there is really no space to finance anything else.

**DR NKONKI** When CMS was here they talked about a review that was done in 2010. Are the findings of that review available, what were the key findings?

**DR PILLAY** So the CMS review in 2010 attempted to review the PMBs, and in trying to attempt the PMBs, what they were doing was trying to add on more conditions on to the list of PMBs. The financial implications of that, when we discussed them with our colleagues in Treasury, was that the premiums for medical schemes was going to go much higher and the Minister had raised a concern that the focus should be on primary care so that PMBs should be restructured to provide preventative and promotive care as much as it does hospitalisation. The council was asked to go back and relook at the benefit structure so that you can have preventative and promotive care rather than financing only curative care, which is far more expensive and inefficient.

**DR NKONKI** My final question has to do with the relationship between the public and the private sector. I wonder if the Minister could share with us what the experience has
been of contracting with the general practitioners in their national health insurance pilot sites?

MINISTER MOTSOALEDI  Maybe, Dr Bhengu, let me, even though Dr Nkonki has asked question. I think I must review the whole issue. I think the whole issue of primary healthcare, you must view it in view of, for instance, the first slide I showed from Dr Margaret Chan’s structural problems of health, we have got the structural problem here whereby the curative part of health is very strong, it’s not only South Africa, it’s globally. In January I was attending The World Economic Forum in Davos where they are saying part of the expenses in healthcare systems around the world is that countries have run away from primary healthcare and we need to go back to that. It is a very difficult process because those who move on curative healthcare have become so strong, generally. The example was even given by the CEO of the International Diabetic Federation. For instance, he said there are three ways of dealing with diabetes in the world, every doctor knows that. The first one is healthy living, not eating a lot of starch or sugar, exercising, avoiding certain things, you can put your diabetes under control and that is very very affordable, but he said the second one is to poke injections and pop pills. The third one, you start changing organs, things are so bad that you need more kidneys, you need a new cornea, you need what, and he said in the present world a doctor who specialises in the first one is not regarded as knowing
anything what a doctor, it’s not regarded as, oh, but healthy living, eating green things, what is that, it’s not really regarded as an expert. He said the one who changes organs, when they are waiting for you to get really damaged and start changing your organs, he is going to be given a Nobel Prize. That is the world in which we are, and I want you to view that way when we change primary healthcare system. That one is going to be regarded as a Nobel Prize, we’ll be all over. Look at Cuba, last year the World Health Organisation announced that Cuba is the first country to completely do away with mother to child transmission of HIV. That is primary healthcare, in other words it’s is no longer there. Why is that not reported widely around the world? It is the biggest achievement of humanity, to stop mother to child transmission of HIV. That is primary healthcare but it’s not the world is not in that mode or in that direction. That is why we want to talk about universal health courage, affordable healthcare, that is why there is war from America to hear President Obama see affordable healthcare being taken to court. By the way, even here I am expecting a court case. There is a preparation which is going on to stop universal health coverage from going on, via a court case and in that one, one is going to check whether section 27 of the Constitution is strong enough. All those are forces, stopping primary healthcare, affordable healthcare, universal health courage, etc.
So the issue of primary healthcare didn’t happen must be viewed in that way. That’s why in the white paper we said the heartbeat of the new system will be primary healthcare and we believe quite a number of things will fall into place.

The last one about the pilots. One of the things we have learnt, yes, that’s another problem, the moment we started the pilots, all we said in the pilots was we contract private practitioners to work in clinics. Many of them were already doing this but they were not calling it contracting, they were calling it sessions in hospitals. We said, If you must help us, why don’t you go to the clinics and stop the patients there so that the public hospitals should not be over congested and overcrowded, because the patients had been seen at the clinic. Many of them were quite reluctant. We are using a hospicentric method. When you tell a doctor to go to a clinic they don’t know whether you are undermining them. In the past they used to go and now the second thing, they demanded more money. We asked them a question. You have been doing sessions in the hospital, paid this much, we are not contracting you in the clinic, the payment was even a little bit better, because in the hospital they were paid according to hierarchies, according to whether you are a senior and all that. In the contracting on these clinics we are abolishing that but they were still complaining and I asked them, they said, oh, we thought this is NHI, it must pay much better. Now, suddenly, yes, this is NHI we expect more money. So, you know, it is just the way our people are socialised. Then I
have got to start teaching them that NHI is not about money, it is not a pot of gold from where everybody will get money, it is a system of providing healthcare for everybody but things started improving a little bit. We got the service provider who was working with them directly.

The second thing we learned is that we should not be contracting doctors only, that means general practitioners, we should also contract other health workers at primary healthcare level, like physiotherapists, optometrists and we are moving in that direction. How did we learn that? We did a screening at Quintal One and Two schools, the poorest schools in the country, we screened children for what is now called physical barriers to learning, things that will make children not learn, that is eyesight, hearing, speech, because of oral hygiene, and we did three hundred and eighty thousand school kids and we found that one third of them have got either of these three problems, either the child has got a problem of hearing, nobody knows, not the teachers, not the parents, not the child itself, but it is picked up during the screening. The child can’t see very well. The teachers conclude this is a dull child as they always do. We are expecting this child twelve years later will pass matric but there is no chance. What am I coming to? Where do you get an optometrist, where do you get an audiologist, where do you get a speech therapist? They are all in the private sector, and if we can’t go and contract them for these kids, it means those kids are doomed, but if
we go to contract them at the present fees and at the present fee structure which is being forced upon us, if we continue in that direction, it becomes impossible to give those services.

So we have learned during that piloting that we need to pilot these people but the payment cannot be fee for service, it will rather be capitation if school kids like these ones have to be helped. That’s why one of the areas where we are going to start in primary healthcare when we implement NHI is to start at schools. There are twelve million school kids, twelve million kids who are at school in South Africa, and if they can get such a service it will be a huge service to humanity.

**DR Nkonki** Thank you, Minister.

**DR Von Gent** Minister, if you will allow me, I have two follow up questions to Dr Pillay, and I have one more important question of course to you after that. You said that not everybody was enthusiastic in your time when you cooperated on the REF, the Risk Equalisation Funds. My immediate reaction is, of course not everybody is enthusiastic. There are parties that benefit from the fact there is no risk equalisation in South Africa, and I can bet you a lot on that, that I can guess a big party that is not in favour of having risk equalisation here. Do we agree?
JUSTICE NGCOBO If you could just place your response on record.

DR PILLAY Yes, yes.

DR VON GENT Secondly, on the obligation to evaluate, the legal obligation actually, I think to evaluate the PMB system and package on a two yearly basis, and you explained that you worried about these evaluations. I was actually, I am from a country where we have a PMB system, we have a private, but not for profit, healthcare insurance system, market wide mandatory system and we have yearly cycles of evaluation of this package, very thorough, every year because it is a very complex phenomenon, there is a lot of influence of technology and the dynamics in the industry that need to be incorporated in this package. I was surprised to learn that actually there has not been a full cycle of the evaluation been going on in South Africa, and during the public hearings that we held, and Minister you were there for the first two days, I think full days, I admired you sitting there these full two days, you heard the first lady presenting to us about the confusion of these vulnerable people actually on what PMBs actually are, but also the confusion with schemes, with doctors, there is a lot of confusion, it is very complex, and an evaluation would, I think, signal that problem and would help in clarify and assist CMS in clarifying what constitutes a PMB claim and what does not constitute. For example, Minister, you were there when Mrs Drescher
explained that there is a lot of confusion about bipolar mood disorder and major depression, and she was in the first instance told by her scheme, a large scheme that major depression is not a PMB. She herself found out that it is a PMB. That leaves your upcoding narrative valid because I think a lot of people think major depression is not a PMBs, but it actually is. So if everybody thinks it’s not, then there can still be a lot of upcoding going on. That is not my point. The point is there is a lot of confusion and I think these regular evaluations would signal that and would signal you and the CMS to do something about it. Can I have your comments on that?

DR PILLAY  On the information for patients on understanding PMBs, I think it is about three years ago now, and I persuaded the Council to embark on a strategy that would try and simplify the option, the benefit options, so that when a consumer reads it they understand exactly what their benefits are and how the PMBs can be accessed, and I think that project the Council had demonstrated what they had been trying to do. It is a complex area because often these benefit packages are put together by actuaries, and I think by the very nature of the way they are structured, they lend themselves to the complexity, and so I think working with consumers may be a helpful way, and I was encouraged by Ms Dreschers proposal that she actually evaluates those benefit options to test whether she actually understands them, and if she did, then it would mean it would go a long way in trying to define these packages.
DR VON GENT  Yes, and she could, she was now taken on board by this large administrator but she could also have been approached by CMS to help from their side guide the schemes administrators to do a better job. Anyway, I think we are in agreement on this. Minister, can I ...?

MINISTER MOTSOALEDI  But, doctor, before coming to that, you know I might be wrong, we appreciate very much countries like the Netherlands, where you’re saying you have got that scheme for everybody, and you're certainly prepared to learn from other countries, but the example you have given about review, I was asking myself even that day when I was listening to the lady, for instance let’s take an issue like VAT, quite a number of foodstuffs are zero rated for VAT. How many general members in the general public will able to have that common knowledge and challenge the providers that this one is zero rated, etc.?

My understanding is that the moment the government makes that law, it is already incorporated into their tillings, billing systems, tilling, etc. etc. and I might be wrong. I thought the reason that that lady experienced that problem is that medical schemes will easily know what a PMB is because they will go to the list, incorporate in their systems, but it is not in their interest for people to know, neither doctors, and that is why, for instance, they were saying specialists are much better than, for instance, GPs
because specialists only have to know PMBs in their field, of work in their field. For the GP it means [indistinct] but if a medical aid scheme could go and comply and say enter this in our systems already it would be easy. So it is also a structural problem of perverse incentives of what the PMB is and what is it going to do to me. The second thing that worried me, many people seem to be thinking we can solve this problem just by making sure that the PMBs are working very well.

**DR VON GENT** No, I agree it is a complex system and it is also a complex phenomenon, and I must be, and I do think we share that there are, there might be schemes that take advantage of the fact that is complex, so I appreciate that. Over the weeks we have heard stories like Mrs Drescher which personally convinced me that a bit more guidance and clarity on the system could benefit South Africa.

Minister, so we talked about risk equalisation, mandatory membership is one of the other issues that has been raised, of course, a lot of times. You, in your response to submissions made to the Competition Commission, you mentioned that also yourself, you said mandatory cover is recommended by all the participants whose side challenges with the current voluntary environment. It’s an issue that has been raised by a number of parties. It has been raised by Discovery Medical Health before and the way you typify the evidence presented to us by Discovery Health, that is rather
anecdotal and not systemic, but the evidence that has been presented to us and even this morning has been presented by Insight, I think you can’t do away with calling it anecdotal anymore, I think it is more like systemic.

I asked the gentleman that presented this morning, the actuarian that presented this morning about the effects and about whether he thinks it is anecdotal or systemic and he is fully convinced it is systemic, and he says also his profession, his colleagues in the industry, so the actuarians are convinced of the effect that the lack of mandatory membership in South Africa adds to costs and adds to the premiums that people in South Africa have to pay. I asked him how much it adds to costs and he says that in his estimation is that it adds to 15% of the cost that people pay for membership of a medical scheme. That is a lot. That is a lot of money. That adds to R20 billion.

I remember you saying that we pay GPs in South Africa, what was it, R6 billion to R7 billion? I mean you can pay a lot of GPs from that amount of money. So, and I know that you have been hesitant in the past about mandatory membership and it is not an easy decision, but would the same go, as we discussed risk equalisation, that you would consider the evidence provided to you to reconsider your position on mandatory membership?
MINISTER MOTSOALEDI  I am sorry, doctor. I think I need to go and think deeply about that question because I don’t really possess clear understanding at the moment, because I was of the opinion that universal health coverage is going to be a mandatory healthcare financing system for the whole population, that was my understanding, and I didn’t know that there is any other way you can do it, and still becomes mandatory, I don’t know for who, for which section of the population, because, yes, in the white paper we clearly said it is going to be a mandatory healthcare financing system to pull funds for the whole population.

DR VON GENT  Absolutely right. In the NHI system, of course, by definition you will have a mandatory system and by definition you will have a risk equalisation system yet one risk pool, but in the interim, and it will take quite a bit of years, in the interim the people that are voluntary paying for insurance pay per year R20 billion, too much if we understand the experts, and that is a lot of money.

DR PILLAY  I think we must look at the evidence but we must also reflect on what the costs of private healthcare are now, and if the Minister introduces mandatory membership, what impact that would have on those households and whether the 15% or whatever the savings is, will actually be realised because, for example many people say, I will employ doctors and the cost of hospital care will come down, but we have
no guarantee of that, right, and so we have to make sure that we are on the right path in terms of all of those claims.

**DR VON GENT** I am fine with that, thank you very much.

**JUSTICE NGCOBO** It is very late, and it’s been day, indeed, but there are just two things that I wanted to mention. At the National Council, that’s the meeting where the Minister and the MEC come together, is that right?

**MINISTER MOTSOALEDI** At the South African Military Health Services that is in general and SALGA because they are also providing healthcare.

**JUSTICE NGCOBO** It there a possibility that until such time that the fate of sections 36, 37, 38, 39, 40 that deal with the certificate of need are implemented or are brought into operation with the necessary regulatory infrastructure, that the Council can perhaps reflect on what can be done in the interim to bring about uniformity in the issuing of licences, in particular, coming with some kind of guidelines about what can be offered to potential applicants so that they know that this is the criteria that would be used in determining whether or not you grant a licence? Is there a possibility for that?

**MS MATSOSO** Yes, I think it’s possible but I would also look at the timelines. If I look at the process of comment for regulations, it is three months, and the National
Health Council meets four times a year and it has had its first meeting. So the timing, it may be perhaps a difference of a month or two or three, but in the interim maybe a guidance document can be shared with the provinces once the regulations are out for comment and consultations are ongoing, I think it’s doable.

JUSTICE NGCOBO  Because, I mean, given what we were told is the potential that these provisions might also be challenged which may further delay the process, but it’s essential that in the interim there is some certainty and some well publicised criteria for determining these licences. The PMBs have been the subject of these hearings since we all started, and everyone seems to be having a complaint about them, in particular their complexity, and one wonders why are they so complex, isn’t there a way of simplifying them? Because we had a letter from a medical practitioner who is a member of SAMA, who wrote in the letter that he didn’t understand the PMBs. So if doctors do not understand these PMBs, who else understands this? Most of the problems of the complaints that we have heard this week turn around the dispute as to whether this particular condition is covered or not covered? Is there a way this can be simplified somehow?

MINISTER MOTSOALEDI  Chief Justice, I think we will go and look into the issue of how to simplify them but, my position will always be that the PMBs were
established to solve a very complex structural problem of health, but we took a short
cut to solve it and that’s why we are in this problem. This was a short cut because they
were not solving the problem, the core. The core of the problem was that there is an all
sort of prices coming from powerful groupings. Instead of looking at that we thought,
no, we could pick up this interim solution, and it solves just one small part of the
problem, because my argument will be that the PMBs, while they are purporting to be
protecting the patient, they are not, they are just making the healthcare system worse.
So I think we need to go back and look at the drawing board.

What was the original problem, what were we trying to solve and how are we solving
it, was it correct solving this way? My position is that it was not. It was not correct to
try and solve such a problem this way, i is much more complex, and when I try to
simplify them but there always remains something that is complex. For instance, the
slide we showed about this activity of trying to diagnose everything with a PMB, I
don’t know how we are going to stop that. These are normal human beings. If they
know that if I write this I get lesser money, if I write that I get more money, tThey are
always trying to find ways to do that. So I personally don’t think the issues we call
PMBs are very desirable solutions of the healthcare problems we are faced with.

JUSTICE NGCOBO Very well. Just one comment on your presentation. You have
drawn attention to some World Health Organisation and the Declaration and the Constitution. There are perhaps three other instruments which constitute the International Bill of Rights, which I think are perhaps quite crucial for the country because they form the foundation of our Constitution. The first one is the Universal Declaration of Human Rights which is really the key international instrument that introduced the issue of right to health, and the other more important one is the International Covenant on Economic, Social and Cultural Rights, which really gives effect to the right to health. As the Minister would have been aware, I think it was last year this country ratified that convention so it is part of our law now. Perhaps the third document is the African Charter on Human and Peoples Rights. Those are some of the key documents that deal with issues that you have addressed in your presentation. Perhaps those will provide you with additional alls.

**MS MATSOLO** Perhaps just to confirm one of the things, in fact the hearings that we have next week are based on those principles, and, like I said, we will share the proceedings of the hearings next week because it is the UN and it is premised on those rights, and what you have read out.

Okay, the Minister said I must disclose what this is about. The UN Secretary General appointed a high level panel that is led by two heads of state, and I am a member of
that panel, to look at access based on the rights, and it looks at broader policy issues on access and IP and pricing and affordability. So there is somehow relevance of that work to work of the Commission.

_JUSTICE NGCOBO_ The important document there is general comment number 14 which was made under the Covenant which deals with addresses, the issue of what constitutes the right of healthcare.

Very well. Minister, is there any other issue that you would like to draw to our attention which you have not had the opportunity to draw to our attention because of the way the proceedings were conducted?

_MINISTER MOTSOALEDI_ Yes. A lot has been said about establishing private medical schools in the country. I did not put it in the slide, I did not respond to it, but I think the time has come that one might have to say something about it. In a country where the student movement is calling for fees must fall and attend, open up education for everybody, now we are sitting here listening to people who want to privatise it. Just compare the two things., whether we are living within the borders of the same country or not, because I have been to a private medical school in the EUA in 2010. By that time the average fee was already R200,000 and the kids I found there from South
Africa, there parents are all millionaires. So we are being asked to establish medical education for millionaires in a country that is at our level.

The second thing in that regard, in the presentation they are putting what ARUAPS is doing, that even the few professionals who are trying to sit at our universities and teach our students are being poached. Now, can you imagine if it’s a law that allows people to establish private medical schools. If that happens, Chief Justice, we might as well close all the medical schools in the country. That is what is going to happen. From our side we are trying to increase them. We are opening, we have opened the ninth medical school in Limpopo. There’s not yet a building but students are learning there. It is going to be the ninth one. [Indistinct] was that the last medical school we built was thirty five years ago. So we just need to start building more and more but if we were to give a licence for a private medical school then we must at the same time start closing down all the medical schools as we know them. I just thought I need to bring that to the attention of the Commission. Thank you.

JUSTICE NGCOBO Thank you, Minister. I know that Dr Pillay suggested that the Department is hoping that we can give answers to some of the problems associated with the implementation, but I think you must understand that we are conducting this market inquiry within the context of competition law and policy, and that being the
case, there are limitations in terms of what we can do. So I am just flagging that just in case you have expectation that we will solve all the problems afflicting the provision of healthcare services in this country. Our mandate is quite limited. Just to draw that to your attention so that you don’t have higher expectation than is necessary.

I think we have come now to the end of this general session of the public hearing, and I would like to thank you, Minister, and your panel for your generosity in your willingness to reschedule your appointment in order to accommodate us. I know that you were supposed to be here yesterday but you were able to reschedule your appointments today in order to make sure that you come and share with us some of your views and provide us with a perspective of the Department of Health on matters that we are investigating, and perhaps thank you for being so candid about the real problem that is facing your Department. We appreciate that.

We do regret, as we have done so in relation to all the other previous presenters, that we have kept you until so late, for more time than you had expected us to keep you.

Finally you mentioned that you will be going to Harvard to receive an award. I think it is proper for us to say congratulations on that.

**MINISTER MOTSOALEDI** Yes, I am going to USA but the award is also being
given to a professor from Harvard, a infectious disease specialist.

**JUSTICE NGCOBO** Well, thank you so much. Congratulations for that achievement.

Thank you. That brings these hearings of a general nature to a close. Thank you so much for your attendance.