Following the Health Market Inquiry Seminar on 30 August, 2016, in Pretoria, the WHO/OECD received the following additional comments from two hospital systems on the 2016 OECD study, "*International Comparison of South African Private Hospital Price levels*" :

a) Nortons, Inc, commissioned paper for Netcare received by WHO/OECD from the HMI on 16 November 2016:

   RESPONSE TO WORKING PAPER NO. 85 RELATED TO AUGUST 30, 2016 HMI SEMINAR ON INTERNATIONAL COMPARISON OF SOUTH AFRICA PRICE LEVELS By Margaret E. Guerin-Calvert, of Compass Lexicon, November 2016 (Henceforth referred to as **Netcare-CL**.)

b) Three papers commissioned by Mediclinic received by WHO/OECD from the HMI on 2 December 2016.

   econex competition and applied economics: Further response to the OECD/WHO report: "International Comparison of South African Private Hospital Price levels" 15 September 2016 (Henceforth referred to as **Mediclinic-econex**)

   PriceMetrics: Comments on the WHO/OECD Response to Critiques of OECD Health Working Paper No.85; 8 November 2016 (Henceforth referred to as **Mediclinic-PM**)

   Michael Thiede and Christian Tuebner, Scenarium Group: WHO/OECD submission to the HMI dated 30 August 2016, Comments, 2 November 2016 (Henceforth referred to a **Mediclinic-Scenarium**)[1]

The following responses provide supplementary information to WHO/OECD's prior responses submitted on 30 August 2016. They are structured to address the specific queries in each submission. Most of the papers repeated the same critiques as in their prior submission. Regarding the same comments on methods, we did not highlight these but kindly refer the Distinguished Panel to our previous presentations. (http://www.compcom.co.za/wp-content/uploads/2016/08/WHOOECD_HMIsubmission2_30Aug16-FINAL.pdf)

[1] Thiede and Tuebner state that their comments "are meant as a constructive contribution to the debate by experienced health economists and health policy experts with a solid knowledge of healthcare in South Africa and no affiliation with any relevant interest group." We note that the Scenarium report was commissioned by Mediclinic and thus implies an important affiliation with a hospital group that has expressed interest in the outcome of the HMI. The authors also refer to the OECD report as a "bad paper," which represents a normative and unconstructive comment.

We note that the critiques – and particularly the papers from Netcare-CL and Mediclinic-PM – attribute to WHO/OECD a series of incorrect statements that are completely out of line with the actual findings and conclusions of the WHO/OECD study, and our prior submissions. We refer the Panel to the actual WHO/OECD submissions and presentations for the accurate responses.

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Section 1. General issues

1.1. Netcare-CL and Mediclinic-PM attribute to WHO/OECD a series of incorrect statements

Netcare-CL and Mediclinic-PM attribute to WHO/OECD a series of incorrect statements that misrepresent the findings and conclusions of the actual WHO/OECD study, and do not consider the explanations already provided during the 30 August 2016 seminar.

We reiterate once again the main findings of the study:

- Prices in South African private hospitals are high relative to South Africa's income level, and on par with the OECD average and much higher income European countries (i.e., France, U.K, and Germany).
- Prices in South African private hospitals are unaffordable for the vast majority of South Africans - even higher income groups.
- Among the countries in our study, prices in South African private hospitals are the least affordable, as measured by the large difference between private hospital price levels and the price levels for all other goods in the economy.

In summary, the study demonstrates empirically that South Africa private hospital prices are on par with OECD countries. However, the services primarily serve South Africans. Thus, they are, at the same time, unaffordable for the vast majority of South Africans, and unaffordable relative to other goods and services in the South African economy.

The study concluded that the current regulatory environment is not effective in controlling price escalation in private hospital services in South Africa, given that price increases are consistently above the level of inflation over several years. While the 2016 paper did not focus on price regulation, this study builds on a previous study commissioned by WHO from OECD in 2014, to inform the national debates on health care pricing in South Africa.

The 2014 study notes that, in most OECD countries, the public sector tends to have some form of price setting for specialist medical services, and this is used to purchase services from the private sector and can provide benchmarks for private insurers. Moreover, developing credible prices and large increases in public spending have been common to OECD countries that have drawn on private sector services to expand access to hospitals in recent years.

The two OECD Health working papers are consistent in recommending that price regulation is done in other countries, and remains an option for South Africa, particularly given the size of the private health care market and the potential destabilizing impact on the health sector as a whole resulting from rapidly escalating prices and health care costs for many households in South Africa.

1.2. Netcare-CL cites papers and analysis that are unavailable to WHO/OECD and the public

The Netcare-CL paper referred to many other papers by Netcare-CL that were unavailable to the WHO/OECD, including for example the "FTI analysis of profitability" (page 10), and Netcare-CL's "extensive expert submissions" (page 16) to HMI. Nor are these papers available on the HMI website. We are, therefore, unable to respond to and to determine the validity of many statements made by Netcare-CL based on underlying data and information unavailable to WHO/OECD, other stakeholders, and the public.

1.3. Total health spending vs private voluntary health insurance spending differ completely

> *Mediclinic-PM claims that the exceptionally high level of private voluntary health insurance spending is not important compared with total health spending (page 8) "The relevant expenditure is the total amount; where it is sourced from is irrelevant."*

We disagree completely that the source of health spending is irrelevant. The pooling arrangements for out of pocket expenditures compared to private voluntary health insurance are indeed significantly different. One cannot compare an individual who pays for services directly out of pocket at the point of service, with the position and price negotiation power of a health insurer, who could be representing millions of members.

Moreover, in South Africa, some 30% of total expenditures in medical schemes are funded from the government general tax revenues. Thus the notion that medical scheme expenditures are "private" is also not correct.

Section 2. Methods and analysis

2.1. Quasi-prices do not represent "costs" but what is actually paid for a given service

> *Mediclinic-PM (para 6) "the quasi-prices used by the authors are unreliable and under-estimate their true values, preventing any meaningful comparison to market prices of hospital services in South Africa."*
>
> *Mediclinic-PM (para 7) "Comparing non-market prices to market prices is invalid."*
>
> *Mediclinic-PM (para 7.2) "the authors claim that public sector quasi-prices are a benchmark for prices in the private sector. The authors provide no evidence to support their assertion which is contradicted by evidence in at least two OECD countries (US and UK).*
>
> *Medicilinic-PM (para 17) "The authors implicitly acknowledge that quasi-prices are not comparable to South African private hospital prices."*
>
> *Mediclinic-PM (para 41) "Key variables in determining a market price include the value created by the product or service and the cost of supply."*

Quasi-prices are the prices paid in OECD countries to public and private hospitals. They do not represent COSTS but what is paid on average in each OECD country for specified hospital services. The term "quasi-price" is used to indicate that such prices are not a result of free markets (e.g. compared to the price of cars where prices are not regulated) in the healthcare sector in OECD countries.

The point of comparison is the cost components of the price (e.g.investment, overheads, pharmaceuticals etc.).

The prices in the report are representative for the country and approved by the governments of each country submitting the data to OECD. The price variation can be caused by various factors, but the OECD methodology includes selection criteria to compare standard case types and averages price for each case type across representative sample of hospitals.

The US is not part of the OECD sample in the comparison study. UK prices in the sample reflect both how much the NHS pays public or private hospitals for services - thus quasi-price is the price paid regardless of whether they are delivered in the public or private sector.

The robustness of the international price comparison relies on the use of the same methodology. The methodology is used uniformly across all countries to get reliable and representative estimates of prices of hospital services and such prices are approved by national governments and statistical offices before submitting to OECD for the purposes of international

comparison. The robustness of the methodology was confirmed by South African experts during the August 30 Seminar (e.g. Insight Actuaries and Consultants).

Consumers are in most instances insured through medical aid schemes and thus do not pay directly the hospital prices. Given information asymmetry, consumers also do not have an understanding of price and value – thus, the purpose and importance of the HMI. Many published documents by HMI point to some reasons that could explain the findings observed in the OECD report.

2.2. Comments on components of the prices

> *Mediclinic-PM (para 7.3.1.) states that "The quasi-prices do not cover the operating costs of producing hospital services such as "research and development expenditure in health" and "training and education expenditure on health personnel."" (para 7.3.4.) "The authors do not adjust quasi-prices for informal and sometimes formal co-payments made by patients which add to the price paid for hospital services."; (para 7.3.6.) The quasi-prices are not adjusted for quality." (para 7.3.7) " The quasi-prices are not adjusted for waiting times."*

South African private hospitals do not conduct any research activities or training which would be part of the price charged to medical schemes for which prices were collected. If so, we would like to ask hospitals to share with us their cost structure for us to be able to investigate whether some adjustment is necessary.

There is no justification to include informal payments in the study. When third party payers set up reimbursement mechanisms and negotiate rates, they do not include informal payments in the payment formula.

The authors provide no empirical evidence of the quality of hospital care in Mediclinic hospitals. In the case that Mediclinic-PM is referring to perceived quality – such as amenities or "hotel" components – it would be useful for the authors to demonstrate that such perceived quality is correlated with health outcomes (e.g. mortality, complications or re-admissions).

The authors are requested to demonstrate empirically that wait times affect the price of hospital services, as this has not been demonstrated in other settings. The report compares prices of hospital services, not the costs/benefits of the economy of hospital sector.

2.3. Details of the sample

> *Mediclinic-Scenarium "the validity of the international comparison of South African hospital price level still depends on the homogeneity of prices included in the sample case types and on the sample composition.*

In their response the authors still fail to disclose relevant data to evaluate the validity of results. In order to clarify these points the authors of OECD HWP 85 should disclose:

1. The composition of cases by case types for the comparator countries for 2011, 2012 and 2013. This serves to evaluate, in how far the structure of the South African sample is comparable or different from the sample structures of the 20 OECD countries and the subset of seven OECD "lower income" countries.

2. For the South African sample: Number of cases, average price and variation coefficients for each case type before and after exclusion of outliers. How many cases were excluded and how did this affect the average price of the case type?

3. Which are the four countries that exceeded the value of 33 % and were they excluded from the study? What are the values for the South African sample (i.e. the three variation coefficients – product, country, and overall variation coefficient - for each case type)?"

When calculating PPPs for hospital services, the individual case type quasi-price is weighted by its value (number of cases multiplied by the quasi-price) over the total value for all case types (sum across all case types of number of cases multiplied by quasi-prices). This accounts for differences in case-mix across countries.

Medical aid schemes provided WHO and OECD with the number of atypical and long stay cases by year (NOT by case type). We show those figures in table 2 on page 13 of the working paper.

Only four countries in this study show a value higher than 33% of the country variation coefficient: Estonia, Hungary, Poland and Portugal. Those countries were NOT excluded from the study though. The variation coefficient for South Africa is 22.3% (25.3% for medical and 20.3% for surgical case types respectively).

For your additional reference, we share with you the attached excel spreadsheet, which shows comparative price levels (CPLs) for GDP and hospitals from the Eurostat website – and it thus publicly available (**Attachment 1**). The attached excel table reports CPLs by country by year. The correlation of the Eurostat and our study CPLs for hospitals by country is 0.97.

2.4. HMI should further investigate: profit margins of hospitals in South Africa

Mediclinic-PM (para 18.3) "It is concerning that the authors appear not to understand that profits are required to ensure that private hospitals survive." (Para 7.3.2.) "The quasi-prices do not include a hospital's cost of capital." (para 7.3.3) "the depreciation rate of 4,8% is implausibly low."

Mediclinic-PM (para 27) refers again to "prices in former socialist republics" noting countries that were not included in the study.

The costs of capital in OECD countries are included in the estimation of the price.

Mediclinic-PM appears to suggest that there are subsidies to hospitals in some OECD countries, which is not justified empirically. In many OECD countries, the prices paid by third party payers (e.g. social health insurance funds, NHS) are same or similar when paid to public or private hospitals. This implies that, when private hospitals accept these prices, they can cover their costs of providing these services.

Most countries in Central and Eastern Europe have implemented purchaser-providers split, where funders and separated from providers. Therefore, third party payers for hospital services are the sole or most important source of income of hospitals and thus cover the hospital costs.

Mediclinic-PM appears to suggest that hospitals in OECD countries included in this study do not have "positive return on their capital." This would imply that the OECD governments subsidize the hospital sector heavily, which is not the case. Thus, the concern may be the magnitude of the profitability of hospitals in South Africa and in OECD countries. Indeed, this was not part of the study and we urge the HMI to investigate this issue, as it may explain the relatively high price level in South African private hospitals. It would be useful if Mediclinic could provide data about the profit margin of specialists, radiology and pathology, to adequately account for these differences in the price-setting between OECD countries and in South Africa.

Note that 4.8% was added to prices for consumption of fixed capital only for five countries in study: Germany, Hungary, Ireland, Norway and Switzerland. Those countries endorsed this adjustment.

2.5. Selection of procedures used in the analysis is standardized

> *Netcare-CL claims that the WHO/OECD report is "cherry-picking" procedures, by citing an increase in hip and knee surgeries of 32% and 54%, respectively, between 2011 and 2013, and a 75% rate of caesarian sections in private hospitals (page 11).*
>
> *Netcare-CL" The extension of medical scheme membership to a wider population may drive increases in procedures in the private sector that are not prioritized by the public health system." (page 11)*

A basic principle for price comparisons is that items should be comparable and representative. 'Representativeness' already suggests that a list of items is not exhaustive in that it covers all hospital activities. Indeed, exhaustiveness is not required if the selected case types are considered representative for a broad set of activities.

The following criteria were used to identify representative and comparable case types. They should:

- represent common procedures or diagnoses;
- account for a significant percentage of hospital expenditures;

- represent procedures which are likely to be the principal procedure within one hospitalisation (for surgical case types); and
- represent well-identified conditions (for medical case types).

The initial selection of case types was based on a list of inpatient case vignettes (Huber, 2007), on a proposal by the Expert group on procedures under the Hospital Data Project (Smedby, 2007), and on the list which was used at the OECD for Health Data collection. This initial list was refined on the basis of the results of several OECD and Eurostat pilot studies carried out between 2007 and 2012, including:.

Huber, M. (2007), "International comparison of prices and volumes in health care among OECD countries. European Center for Social Welfare Policy and Research", paper presented at the first meeting of the Task Force for the Development of Health-specific Purchasing Power Parities, Paris, 8 June.

Smedby, B. (2007); A selected list of hospital procedures for international comparison. Report on the work of the expert group on procedures under the HDP2 project. Presentation at the OECD Health Data National Correspondents meeting, Paris 9-10 October 2007.

Regarding the exceptionally high rates of caesarian sections in private hospitals, the OECD report findings are consistent with other reports, including annual reports of the Council for Medical schemes. Please refer to the CMS Annual report 2015/16, Annexure E: Utilization of services for the years ended 31 December 2014-2015, where CMS reports that the Number of caesarean sections performed (per 1000 female beneficiaries) was 667,46 in 2014 and 674,8 in 2015 (see page 9).

Regarding the "extension in medical scheme membership to a wider population", the CMS reports that the average membership for year 2011 was 8,410,737 beneficiaries in 2011, 8,605,669 in 2012 and 8,754,305 in 2013. This represents around 2% increase of beneficiaries every year. Thus, such extensions in memberships that could plausibly alter utilization patters do not appear to be taking place (**Figure 1**).

Figure 1. Average number of beneficiaries in medical schemes, South Africa (source: CMS)

Year	Number of beneficiaries
2011	8,410,737
2012	8,605,669
2013	8,754,305

2.6. Further analysis is possible to examine competitiveness and price components

a) Analysis of Competition and profit margins

Netcare-CL again repeatedly stated that the OECD study did not carry out a competition analysis, which was well beyond the scope of the study and arguably must take into consideration the health market failures.

While the study did not address the issue of competitiveness, it would be possible for the HMI to expand on the OECD methodology to analyses whether the prices are "anticompetitively" high by analyzing the same sample of case types by individual medical schemes and individual hospitals comparing the prices and relative market powers within the relevant markets.

In addition, a profit margin analysis could be informative for HMI to study the differences in price levels between medical and surgical services. The paper noted substantially higher comparative prices for surgical services, suggesting that this is an important area for further investigation (**Figure 2**).

Figure 2. South African Private Hospital Price Levels relative to 20 OECD countries, 2011-2013 (0=OECD mean)

	Comparative price levels		
South African sample	*2011*	*2012*	*2013*
Hospital - medical services	87	83	75
Hospital - surgical services	119	114	105
Hospital – total	108	103	94

b) Cost component analysis

The study collected prices of hospital services, not on the provider cost structure, which might be influenced by the prices of imported goods. The input costs of some imported goods might be influenced by changing exchange rate, but it is not clear how such changes are reflected in the prices observed in the absence of additional date from private hospitals. With the current data, we are unable to determine the share of the hospital component dedicated to pharmaceuticals and medical devices. Moreover, South Africa is not unique in importing pharmaceutical and medical products to deliver health services. The impacts of exchange rate variations are present in all countries. Given that the calculation of price per case is the same, this enables a price comparison across all countries regardless of the source of the product.

We have provided to the Health Market Inquiry formats to collect additional data to determine the more detailed cost components of the price. It is also possible that Netcare and Mediclinic provide these data themselves.

2.7. Mediclinic-econex repeats their prior comments

The Mediclinic-econex critique repeats their prior comments on the methods. We would therefore maintain the same responses on the methods, and would urge the Mediclinic authors to read carefully our previous presentations and submissions. We note that the methodological concerns repeated in the critique are addressed one by one (please see pages 14-36 http://www.compcom.co.za/wp-content/uploads/2016/08/WHOOECD_HMIsubmission2_30Aug16-FINAL.pdf)

As noted in our prior response, when reporting on "hospital prices," this is defined as the price of the whole episode of care. We note in the study that hospital share represents in excess of 60% of the total share of the price. We refer the authors to the study methods and definitions.

We note that there is a misunderstanding from Mediclinic-Econex, which represents the perception of the CPI and the hospital price increases from the consumer's side. Consumers do not understand the cost drivers of various industries, but they perceive the price increases of goods and services that they consume – which are measured in CPI. In the same manner, the hospital service price increases are observed by consumers (and/through medical aid schemes) and thus can be compared. The situation where medical inflation is higher than CPI should not be taken for granted, but should be studied and understood. This should be part of the HMI deliberations.

Section 3. Framing of the analysis

3.1. Service delivery platforms are amenable to policy change

> *Netcare CL, Mediclinic-econex continue to propose an alternative framing of the analysis that start with the hospital based service delivery model, which is an important source of inefficiency in the South African health care sector.*

The starting point for the OECD analysis is a medical or surgical case. The authors seem to suggest that the starting point should be the service delivery model, and propose that the analysis should first select countries with inefficient service delivery models and then compare prices. Hospital based service delivery platforms do result in higher prices - but without gains in quality or health outcomes.

As noted previously, rapid increases in prices and total health expenditures can be seen in countries characterized by fee-for service payment mechanisms, lack of price regulation, lack of mechanisms to control service volume, and hospital based service delivery platforms. These characteristics are present in the South African private health care market. They are amenable to policy and regulatory change.

3.2. GDP is commonly used to compare countries internationally

> *Mediclinic-PM (para 31.1)"Using GDP per employee as a comparator to hospital price levels, we show that the claim that South African private hospital prices are "high" relative to OECD countries is seriously weakened." (pare 31.2) "Prices are determined in markets based on demand and supply factors specific to that market and not by macroeconomic variables."*
>
> *Mediclinic-PM (para 31.4) "The WHO/OECD methodology is of little relevance to internationally non-tradable goods, which include South Africa hospital services. While prices of tradable goods are set in world markets, prices of non-tradable goods are determined by domestic demand and supply factors. Whether prices are "high" or not cannot be inferred from international comparisons of prices."*

South African hospital offer services to all South Africans. The affordability analysis compares general price level and hospital price level indices. Private hospitals purchase most of their inputs on South African market and thus predominantly face the local price level. The difference between these two price levels was used to measure affordability.

GDP is used to compare countries internationally – in health care and other sectors of the economy. The work adds to the creation of the PPP (purchasing power parities), and

international standard for comparing prices across countries. The PPPs adjust for the differences between the local and international price level and income differences. This was included in the study and thus replacing nominal exchange rate the hospital price level was adjusted for these differences income levels.

The issue of tradable and non-tradable goods applies to all countries in the same way. The situation in South Africa is comparable to other countries.

Section 4. Assumptions on health care markets and goods

4.1. Health care markets do not function like other markets.

Netcare-CL persists in stating that "there is substantial support for reliance on competition policy in health care…" but Netcare CL continues to offer only anecdotal reports and ideological opinions rather than empirical evidence about the appropriate level of competition in health care. To justify their statements, they cite a 2004 report produced by the US Department of Justice, Federal Trade Commission.

Health care markets do not function like any other markets. Health care markets are characterized by deviations from the assumptions of perfect competition – and such deviations result in inefficiency. These issues were first articulated in a 1963 article by Kenneth Arrow, and include uncertainty about the demand for care (its timing, duration, and costs, for example) and information asymmetries.[2] **The critical implication is that, in environments of imperfect competition, government intervention is required to promote efficiency and correct for health care market failures.** Since this seminar work, the appropriate level of competition in health care markets continues to be highly debated, as are the conditions under which specific policies can be effectively utilized to promote price control, quality, and health outcomes.[3]

Cited by the authors, the 2004 US Federal Trade Commission paper poses questions about whether competition provides the most appropriate means to deliver socially optimal level quality care, and states from the onset that "*The proper role of competition in health care markets has long been debated*" (page 5). It could be interesting for the HMI Panel to note that the US Federal Trade Commission has been very active in challenging hospital mergers as part of its mandate of antitrust enforcement, to prevent hospitals and other health care entities from gaining undue market power through mergers and acquisitions. The FTC cites studies reporting relationships between excess market power and higher prices,[4] lower quality,[5] and less innovation.[6] Relevant to the HMI work, the US FTC also found that US hospitals acquired physician practices, which increased their market power; but that it was not necessary for hospitals to employ physicians to promote integrated health care and quality.[7]

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[2] Kenneth Arrow; Uncertainty and the Welfare Economics of Medical Care; American Economic Review Vol LIII No. 5. https://assets.aeaweb.org/assets/production/journals/aer/top20/53.5.941-973.pdf

[3] US National Academy of Social Insurance; Addressing Pricing Power in Health Care Markets, April 2015; http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000212-Addressing-Pricing-Power-in-Health-Care-Markets.pdf

[4] Gaynor and Town June 2012. The impact of hospital consolidation- Update http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261

[5] Martin Gaynor, Rodrigo Moreno-Serr, Carol Propper; Death by Market Power, American Economic Journal: Economic Policy vol. 5, no. 4, November 2013 https://www.aeaweb.org/articles?id=10.1257/pol.5.4.134

[6] Havighurst & Richman; Provider Monopoly Problem in Health Care; Oregon Law Review; March 2011 http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2905&context=faculty_scholarship

[7] Julie Brill US FTC Competition in Health Care Markets January 26, 2015. http://healthaffairs.org/blog/2015/01/26/competition-in-health-care-markets/#_ftn1

4.2. Health care goods are not ordinary commodities

Netcare-CL continues to treat health care as any commercial commodity– similar to oil and gas (page 10) – thus proposing to evaluate price in terms of economic costs and returns. However, health care is not an ordinary commodity.

We emphasize that health care is a right for all citizens. Universal political commitments to health exist, which aim to ensure universal access to health care. Health is recognized as a human right under the Universal Declaration of Human Rights established in 1948. The Covenant on Economic, Cultural, and Social Rights, which South Africa ratified for entry into force in April 2015, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Most recently, the Sustainable Development Goals for 2030 was endorsed by all United Nations member states, and commits to ensuring universal health coverage by 2030. The commitment to implement universal health coverage reflects the values of equity, fairness and social solidarity. It also establishes that health care is not a commodity, employment perk or privilege, but it is a social right for all.

In the Bill of Rights of the South African Constitution, Section 27, states that "Everyone has the right to have access to…health care services… The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights." This is consistent with the international declarations and commitments around universal health coverage and, in particular that this right to equal access to health services relates to the whole population. Thus, government is obligated to act in order to ensure the progressive realization of this right. High prices and high costs in the private sector drain resources away from the majority of the population, and hence undermine this objective. From this perspective, under the South African Constitution, the government is therefore obligated to take action to address these prices and costs because of their implications for achieving equal access to health services.

Such action has been reflected in South Africa's National Health Insurance (NHI) White Paper, which realizes the constitutional commitment for the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to have access to health care services including reproductive health care. The NHI White Paper recognizes the values of justice, fairness and social solidarity. Its implementation is consistent with the vision that health care is a social investment and should not be subject to market forces. It also recognizes health as investment that contributes towards improved human capital, labour productivity, economic growth, social stability and social cohesion.

Section 5. Price regulation

5.1. Price regulation is a policy option that other countries utilize to address high health care prices, and it remains an option open to the Government of South Africa.

Netcare-CL continually argued against price regulation, which was not among the main findings of the 2016 study. However, it was the focus of a 2014 OECD paper, commissioned by the WHO for South Africa: Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing. Available for download at http://dx.doi.org/10.1787/5jz2lpxcrhd5-en

Mediclinic-PM (para 13) states that "In the absence of any model or theory to explain their empirical data it appears now there is no policy recommendation by the WHO/OECD." (para 12) "the WHO/OECD no longer argue that private hospital prices should be controlled."

The study concluded that the current regulatory environment is not effective in controlling price escalation in private hospitals in South Africa, given that price increases are above the level of inflation. While the 2016 paper did not focus on price regulation, we noted a previous WHO commissioned paper from OECD to inform the national debates on health care pricing in South Africa. (*Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing. Available for download at http://dx.doi.org/10.1787/5jz2lpxcrhd5-en).* This study made the following conclusions (page 7):

1. *South Africa has a higher share of spending on private voluntary health insurance than any OECD country, and this serves a smaller share of the population.*
2. *In most OECD countries the public sector tends to have some form of price setting for specialist medical services, this is used to purchase services from the private sector and can provide benchmarks for private insurers.*
3. *Regulation in OECD countries generally enables collective bargaining on hospital prices. Competition policy distinguishes between public insurers with a social purpose and private insurers, and allows coordination among providers under specific circumstances.*
4. *Developing credible prices and large increases in public spending have been common to OECD countries that have drawn on private sector facilities to expand access to hospitals in recent years.*

The executive summary of the study concluded with the following paragraph (page 7)

A suggestion from this review of OECD countries is that South Africa should separate the 'technical' task of establishing a schedule of medical services ranked according to their complexity from 'political' negotiations over overall payments to medical professionals. A technically sound price schedule is a common feature of OECD country health systems. It brings clarity for doctors, those that pay them, and ultimately, the patients that these institutions serve. Today, the South African health care system lacks this clarity. This makes it hard for the public sector to draw on private health care services to expand access to care, and makes negotiations between private insurers and private facilities a more difficult process.

The two papers are consistent in recommending that price regulation is done in other countries that rely on private providers for health delivery, and this remains an option for South Africa – particularly given the size of the private health care market and the potential destabilizing impact on the health sector as a whole resulting from rapidly escalating prices and health care costs.

5.2. Netcare-CL comparisons with UK and South Africa must take into consideration policy environment

Regarding the Netcare-CL comparisons with the UK and the US, we note the following differences in the health care markets that affect the policy responses (**Figure 3**). First, spending on private voluntary health insurance in the UK amounts to 3.4% of total health spending compared with 43% in South Africa. Thus, while policies in the private health care sector in South Africa could have a destabilizing impact on the whole health sector, this is unlikely to be the case in the UK, where the sector is small relative to total health spending.

Secondly, we highlight in figure 3 the share of population covered by supplementary and complementary private health insurance. In many countries in Europe, coverage is very high such as 90% coverage of complementary insurance for user fees in France and 84% complementary coverage for additional services outside of the public benefits packages in the Netherlands.

Figure 3. Spending on private voluntary health insurance, population coverage, and services covereed, categorized by main voluntary health insurance role. (Source: Sagan and Thomas 2016)[8]

	Country	Private voluntary health insurance as % of total health spending	% of population covered by private voluntary health insurance	Populations covered or services covered
A. Substitutive: covers people who are uneligible for public				
	Ireland	14	0.4	Those not entitled to publicly financed cover (people newly resident, during first six months of stay)
B. Complementary: covers user fees				
	France	13	90	Full cover of coinsurance for most services; varying cover of the cost of convenience medicines, medical devices and extra billing; no cover of deductibles
	Slovenia	14	84	User charges for all publicly financed health services
C. Complementary: covers additional services				
	Netherlands	5.9	84	Eye and dental care, physiotherapy, speech therapy, some preventive care, some forms of cosmetic surgery, CAM
	Denmark	1.8	38	Eye and dental care, physiotherapy, psychiatric care, chiropractic, medical aids, chiropody
	Germany	8.9	27	Dental care
	UK	3.4	5	Dental care, CAM
D. Supplementary: amenities, choice, faster access				
	Switzerland	7.4	70	Choice of physicians within hospitals, double or single hospital rooms
	Ireland	14	47	Semiprivate/private rooms in public/private hospitals, faster access
	South Africa	43	16	Private hospital access, faster access
	Georgia	19.2	10	Access to better hospital amenities
	UK	3.4	9	Faster access, choice of private provider and of specialist acting in a private capacity, better amenities

[8] Anna Sagan and Sarah Thomson, Voluntary Health Insurance in Europe: Role and Regulation 2016; http://www.euro.who.int/__data/assets/pdf_file/0005/310838/Voluntary-health-insurance-Europe-role-regulation.pdf