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Comments on Health Market Inquiry – Nimpa Ltd.

These comments are provided for consideration by the Commission in accordance with the invitation to comment. The comments focusses only on certain aspects of the report and in as far as we are ale to provide relevant input into any Recommendations by the Commission. Where we have not commented on certain sections of the Report, such omission may be taken as a reservation to comment. The relevant sections where we have provided comment, have been referenced as per the Report's headings.

1. RECOMMENDATIONS TO FUNDERS

1.1 GENERAL

- An environment that seeks to promote alternative models of care should place more focus on day hospitals or sub-acute facilities, as this would also serve to lower cost of treatment. This cannot be done from the Funders' side alone and the government approving bodies must ensure that the facilities exist for these funders to promote lower healthcare expenditure.

- Multidisciplinary team based care can be driven by linking to centers where multidisciplinary healthcare is offered. Co-Ordinator roles of GP's also to be bolstered by promoting use of alternative care such as day hospitals as opposed to acute hospitals. Innovative forms of care must be less restricted than under HPCSA rules. Again as per the above, this cannot be achieved by following the same system currently dictated by the HPCSA. Employment of doctors are also being hampered by the HPCSA. This needs to change in order for schemes to be able to adapt. In this regard, we are in support of the HMI's finding with regards to the HPCSA Ethical Rules and the application thereof.

- The way in which the HPCSA imposes its Ethical Rules should not influence accessibility to healthcare.

1.2 ACHIEVING STANDADISED BENEFITS

- The base package option mentioned in the Report should also provide for claims back from medical schemes to be treated the same if seen by any practitioner, as a difference in treatment of a claim will again have the result of the benefits not being comparable.

- Regionally based schemes will not be able to compete when looking at a standard base package, since they will not be able to provide for the same cover at the same cost across the country. The members will in the end be negatively influenced by such a model. It would also not be possible to exclude national schemes from participating in these regions, as they would have members everywhere.

1.2.1 Risk Adjustment Mechanism –

- If the CMS is the initial facilitator of the RAM and the CMS for some reason does not perform well or does not meet the recommendation proposed by the HMI, it would be difficult for a new authority to apply the model correctly. In the absence of a proper authority to initiate this model, it is likely to cause more problems than it solves and may create another inadequate system provided for one purpose, but which does not achieve its target.

- If the CMS is the initial facilitator, this would mean that there would initially be job-creation within the CMS. If this RAM was to migrate to another administrator and the CMS's model does not fit the plan of the administrator, there will be job losses and may lead to a shortage of required skills as opposed to the right skills for the right job.

- The RAM will have the effect that there will not be any competition for members in the same demographic, as schemes will all be on the same footing regardless of their member demographic. In our view this will only have the effect of schemes aligning themselves more towards one type of demographic they are targeting for their supplementary packages, since they will either be a high- or a low- risk scheme. Schemes may in other words opt to target a certain demographic based on this model and thereby provide more exclusive supplementary packages to its members.

- By instituting a contribution subsidy for lower earners and especially in South Africa with the difference in earnings being very wide, a large number of lower income members will be "carried" by higher income members. This does not promote equality in treatment of members and their contributions. One may also encounter schemes avoiding a certain demographic of earners in order to avoid this problem which will further demotivate competition.

1.2.2 Additional/Supplementary Benefits

- Caution is to be excercised in providing standards for supplementary benefits, as excessive requirements will again lead to schemes not being able to compete effectively.

1.3 PMB's

- If there is a difference in treatment of claims from certain providers, the standard base package will not be effectively comparable prior to the choice of scheme.

2. RECOMMENDATIONS FOR SUPPLIERS OF HEALTHCARE SERVICES

2.1 SUPPLY SIDE REGULATION OF HEALTHCARE

2.1.1 Facility Licensing

- The issuance of licenses by provincial authorities need to be standardized. If there is uncertainty in the consideration of granting of licenses, new entrants in the market will continue to be discouraged from providing for new and innovative forms of healthcare.

- In considering stakeholder submissions in devising a national plan, the Department of Health must ensure that necessary weight is given to the smaller- or prospective new entrants in the market. As it stands, by the HMI's own findings, the market is dominated by three major groups and this needs to be borne in mind when trying to invite more competition, especially from new entrants.

- The National Department of Health, as well as the Provincial department must be monitored to ensure that decision makers are impartial to applications and applicants. This must also be ensured when devising a national plan.

- Reporting by facilities on data required by the Department needs to be more strictly monitored. This should for instance make provision for audits by the Department or compulsory independent audits to ensure accurate reporting. The existing facilities and groups will have an interest in under- or over-stating their occupancies for instance, dependent on their then current strategy. If these reports are done without proper validation, the Department may again be lead to rely on incorrect or incomplete data.

- When considering applications for facilities, the data provided on the publicly accessible database should be the measure against which the Department makes a determination.

- Measures should be put in place to disallow information that differs from the available information.

- Sale of licenses should be made public for objection/comment by stakeholders in line with the objectives of the national health plan and licensing framework.

2.1.2 Practice Code Numbering

- Practice Numbers in group and multi-disciplinary practices should be allocated to a certain group or practice and remain that group or practice's practice number, similar to how it should work with individual practices. The practice of the BHF to allocate new practice numbers and require name changes in every event where a practitioner leaves a practice or a new one joins a practice should be scrapped. This method is wasteful and time consuming and serves no purpose, especially in light of personal practice numbers (in the new framework) accompanying any claim. Practices such as this which is wasteful on time and on money, should be investigated and discarded.

2.1.3 Health Services Pricing

- Proposal 1: Regulated Pricing – If a global FFS is set by the regulator, there will be no competition in respect of uninformed consumers. Informed consumers will be able to determine (to a certain extent and based on the outcome of the recommendations of the HMI) the best value for money service providers. However, if a person is uninformed, he/she will simply depend on convenience and little- or no other factors will become the deciding factor for a consumer. This will not promote better primary care being provided by a practitioner, as the outcome of the care will not have a substantial baring on its earning potential. This has exactly the same effect as bargaining by an association would have, as prices would be set and funders and consumers will have to

accept the set price. Further, if FFS for non PMB's become a reference price only, they would again become subject to collective bargaining and would similarly have no different result. The regulator would have the means to determine a provider's income, which may be unacceptable to providers. This will undoubtedly lead to a decline in healthcare providers on the one hand, and quality of service on the other hand. Proposal 1: Regulated Pricing is highly unadvisable.

- Proposal 2: Multilateral Tariff Negotiation – For proper comment to be provided on this option, the framework that the regulator proposes on implementing for the negotiation to take place, needs to be clearly set out and communicated for comment, prior to implementation. As it stands, there is not enough information available for stakeholders to provide meaningful input. In addition, if the regulator, with the affirmation of law or regulation, provides for arbitration, stakeholders are to be advised of the discretion/room that an arbitrator would in effect have, considering that the HMI is proposing variations in law and regulation in order to provide for the implementation phase of recommendations made. If there is uncertainty on what the arbitrator will be able to adjudicate on or on the discretion/room available to him, providers will not have confidence in the proposal. If this stage is reached without any confidence in the system so provided, the same/similar problems will occur as with Proposal 1.

- In considering changing the FFS model, the commission must also consider that the consumers have to exercise discretion in buying. This is the same with any market, where a consumer judges the quality of purchase with the cost of the product or service and decides for him/herself what they choose to purchase and what to abstain from.

- We are fully in support of the move towards alternative reimbursement models and away from FFS pricing.

2.1.4 Coding Systems

- If the SSRH does not take over the coding function, there would at least need to be some collaboration between the custodian thereof and the SSRH, since the SSRH will seem to be the forerunner in determination of fees, whether it be FFS or alternative models later on.