JUSTICE NGCOBO I think we should all get seated so that we can get on with the business of today. I wonder if somebody could just alert people who are still outside that we are about to start thank you. I think we should start this is the second day of the first set of public hearings. You would have noticed from the program for today, that we will be hearing oral submissions from Section 27 and Partners, World Health Organization and Organization for Economic Co-operation and Development and the last submission will be from the Congress of South African Trade Unions, so we will commence with Section 27.

Perhaps for the record, if you could just state your name for the record?

MR HEYWOOD Good morning Justice Ngcobo and Members of the Panel, my name is Mark Heywood and I am the Executive Director of Section 27.

MS RUGEGE Good morning my name is Umunyana Rugege from Section 27.

JUSTICE NGCOBO Mr Heywood you have a list of individuals and organizations that you intend to bring in, is that right?

MR HEYWOOD That is correct Justice Ngcobo.

JUSTICE NGCOBO I wonder if you could just give us a roadmap of how you propose to deal with this, so that at least we are mentally ready to assimilate?

MR HEYWOOD Absolutely, it was part of my plan Justice, but I will quickly run through it and then I will come back when I start the main submission, but the panel has kindly given us 9:30 to 11:00 and then a second session to bring in our partners another hour between 11:20 and 12:20. The way we intend to use that time, is that as the Director of Section 27, I will make a 10 minutes introduction to these issues. My colleague Umunyana who is an Attorney at Section 27, but who specializes in work on the private healthcare sector in particular, will then make a longer submission on some of the issues that are involved.

We will leave time before the tea break for any questions that you should have and then after the tea break, we will be giving our time over to partners as you have said of Section 27 whose submissions and evidence are relevant to your considerations and who will speak about the specific areas that they

are operating in, working in, be it depression or be it rural health or be it HIV, that is the roadmap.

JUSTICE NGCOBO Would those be individuals in the organization that are listed in the program?

MR HEYWOOD Yes Justice with 2 exceptions. Regrettably and I think it is pertinent at this type of enquiry, 2 of the individuals Sandile [Brinkwest] and Ms Phindi Mlotshwa, 1 of them is in hospital and the other is just not physically able to join us today, but we have included their written evidence in our written submissions of both of those people.

JUSTICE NGCOBO Okay very well, okay you may commence thank you.

MR HEYWOOD First of all, on behalf of Section 27, we would like to thank you for setting up this enquiry. We think it is a very important inquiry and we look forward to the report of the inquiry. We think that it is important because we have seen as Section 27 and I will say a little bit about our organization in a minute, almost 10 or twelve years of an impasse between the providers of public health, the public sector and the private sector, between the Minister and private providers over issues of regulation, over issues of

price and during that time as you can see from the Minister's submission, we have seen an escalation in prices in the private healthcare sector which I will come to in a minute, which have made access more and more difficult for many people and have increased the burden of care on the public healthcare sector.

That leaves me to why we would want to make these submissions to you as Section 27 as I think certainly you know and your panelists know Section 27 is an organization really a public interest law firm that focuses on Section 27 of the Constitution the right to healthcare services and so on a day to day basis, we are engaged with constitutional questions around people's rights of access.

Now you probably see us in the media quite often in confrontations with our colleague the Minister of Health over issues around quality in the public healthcare system, but I have to say that as important, is issues that hover above the other parts of our health system which is private healthcare and the relationships between public and private healthcare because they don't operate in separate universes, the 2 universes as you will hear over the next few weeks and as you will hear from me, frequently collide one to the

detriment of the other, so we deal with clients who come to us and you will hear some of them today in despair quite frequently about the termination of medical care because their medical aid benefits have run out.

I am going to give you a particularly close to the heart example later on in relation to cancer treatment, but we grapple to deal with these issues and so what I am saying, is that we are really looking to this panel in a sense to break the impasse. Now what we would like to present to you after I have made my submission, is that Umunyana will speak partly to our written submission, further developments since we made the written submission, but I would just like to say a little bit about our partners and pull out some of the themes that we would like you to interrogate when you hear our partners before I complete this submission.

You will hear from the rural health advocacy project, they speak for themselves obviously but work in the area of rural health and are concerned with equity and equality in access to healthcare services. You will hear from them themes about skewed access to healthcare if you live in a rural area, both public and private healthcare. You will hear from them issues about the dangers that without proper regulation of the private healthcare sector in

particular, that there is a danger that the National Health Insurance proposals might actually further exacerbate the inequalities that currently exist between rural and urban when it comes to access to healthcare.

You will hear what I think is a very strong submission from the South African Depression and Anxiety Group who will talk to you about the question of prescribed minimum benefits and the adequacy of prescribed minimum benefits as applicable to medical schemes and payments for issues to do with depression and anxiety, in fact, the inadequacy of those benefits. You will hear a common theme that I will return to and I am sure you are going to hear a lot about in terms of the cost of medicines and the cost of healthcare services and the consequences of the unaffordability, the life and death consequences of the unaffordability and you will hear about and this won't only apply to issues of psychiatric or mental health issues, but about discrimination and problems to do with the lack of access to information that consumers for want of a better word, have in accessing private healthcare, what the Department calls the asymmetry, the paralyzing asymmetry between the provider and the user of healthcare which is more acute I would argue in the private healthcare sector than in the public healthcare sector.

You will hear similar themes from the South African Federation of Mental Health, they will also raise issues with you about the essential drug list, the lack of transparency in drawing up the essential drug list and whether things like the essential drug list properly meet the right that everybody has under Section 27 of access to healthcare services or I should say access to appropriate healthcare services for the conditions that are prevalent in this country, of which mental health is a very prevalent but very under-recognized health issues.

From the HIV Clinicians Society, you will hear further about problems with medical aid coverage, you will hear issues that are emerging about the use of courier schemes to transport medicines to patients and you will also hear something that is very important about both public and private healthcare market, is the questions about the quality of care in the private healthcare sector, the quality of care in that market and they are going to speak particularly to the question of tuberculosis, where we would argue there is substantial evidence of a dumping of people who approach private healthcare onto the public healthcare sector and again, a dis-equilibrium if you like in quality between the capability of the public health care system to treat very prevalent, I mean TB is our largest cause of illness and largest cause of

mortality of course HIV is associated, but between the burden that is shared by public and the burden that is shared by private which is particularly a problem given that they utilize fairly similar amounts of financial resources.

Then you will hear from the treatment action campaign who, together with Section 27 have a history of trying to use the Competition Act in trying to stimulate competition in access to antiretroviral medicines, I would say successful use of the Competition Act with complaints previously to the Competition Commission with regards to antiretroviral drugs that way back in 2003, led to a negotiated settlement that led to a very dramatic reduction in the price of those medicines once the market was opened up to generic competition, but Justice Ngcobo, what we would argue and I will come to my concluding comments in a few minutes, is that really the picture that all of this presents, is of quite an anarchic system, of a market that is not working. Certainly a market that is implicated in the Constitution, it is not a car market or a perfume market or something like that, it is a health market.

It's health is governed by the Constitution, but what we see often, is anarchy, we see the parts not working well together, working against each other and we see mismanagement in both systems, but where the mismanagement in the

private healthcare sector ripples into the public healthcare sector increasing the burden, increasing the anxiety of patients frequently and sometimes vice versa but our concentration today is of course on the private health market.

I would like to make 4 points just to conclude before I hand over to Umunyana. The first point is that we would really just like to affirm the way the panel appears to be approaching this inquiry and really beg that you sustain this approach which is to see it in terms of everybody's right of access to healthcare services, the Section 27 right. That is the approach that is taken by the Minister of Health as well and we align ourselves with the Minister of Health in that respect.

But we would go a little bit further and just draw to your attention that the right of access to healthcare services doesn't only occur under Section 27 of the Constitution. You will be aware that as the Chief Justice, that Section 28 gives children a right to basic healthcare services and it is quite different from Section 27 because the right to basic healthcare services is not subject to progressive realization or available resources, it is as the Supreme Court found last year in relation to text books and it is exactly equivalent, it is a

right that there is a duty to fulfil immediately.

We would question in the context of this inquiry, what are the barriers that are impeding access for children to basic healthcare services that continue to contribute to high infant disease, to high infant mortality and is there a proper sharing of that responsibility? There is also the Section 12 right to bodily and psychological integrity and decisions concerning reproduction which of course is a critical issue again in both the public and private healthcare sectors and then there is the right of prisoners to medical treatment that is the language that is used.

So there are a basket of issues that I think all enforce that there is a duty on the Government of this country to take measures, reasonable measures to try to address these inequities and these things.

The final 2 points I would make…

JUSTICE NGCOBO Sorry you will forgive me, sometimes it is difficult to resist these questions when they come up and want to voice them immediately. I take it your colleague at some point will locate the Section 27 and Section 28 rights within the context of Competition law and policy?

MR HEYWOOD My colleague Justice Ngcobo, but actually you have reminded me of something that I was going to do myself, so let me just locate it very quickly, because we are aware there have been some issues as to whether this issue is even relevant, whether it comes under the purview of the Competition Commission or this panel, but what is particularly relevant to us, is that the preamble to the Competition Act uses this language that one of the purposes of the Act is to provide for markets in which consumers have access to and can freely select the quality and variety of goods and services they desire, so there are some key words there, markets this is clearly a market, there are consumers of healthcare, freely select suggests that this information asymmetry is addressed and access is access, but I think that puts it squarely.

Then the second thing is that within the purpose of the Act, the language is used that one of the purposes is to promote and maintain competition in order to advance the social and economic welfare of South Africans and social clearly means health and economic, well if you are not well and you can't afford treatment, it impacts on your economic ability, so let me just conclude with these 3 points very briefly.

I would just like to say the following that we regard the private healthcare as

conducting a legitimate business, it has a right to exist, but we want it to exist in a fashion that contributes to constitutional and national objectives when it comes to healthcare. It needs better monitoring, it is under-regulated and there are issues not only in relation to cost of services, but also in relation to quality of services. Don't think that cost if delinked entirely from quality, but also ask how is it that the private healthcare sector is able to gain its advantage.

I mean anecdotally I was in the hospital for a few days a couple of weeks ago and I asked one of the cleaners how much she earns and she said she gets paid R218 a day, it is the Rosebank Clinic, which obviously is not competitive with what the Department pays to similar people, so where is the advantage?

The second point is that we feel that much of the private healthcare sector is out of joint and unresponsive to national priorities and here, we would say and I am sure the Minister will agree with this, is that in the context of NHI, that a pre-condition of the success of National Health Insurance is the proper alignment of public and private healthcare sectors and both working together to meet a national need.

Finally, we appeal to you, we have heard over the years when it comes to private healthcare, that it is a battle of he said she said, the Minister says this, the private people say this, it is profitable, it is not profitable, it is this, it is expensive, it is not expensive etcetera. We hope that your investigation will bring that battle to an end, because you will conclusively look at the evidence of what is happening in this market and we do believe that regulation could force a different business model that would still be profitable but would at the same time respect, protect and promote rights.

I want to finish if you would just allow me, because I would like to say that this inquiry is about life and death and it is about anxiety, it is about pain and dignity. I have a friend, a colleague in fact, who was diagnosed with cancer 5 months ago with serious cancer, she has spent, it is costing her nearly R80 000 a month in the private sector. She has spent R380 000 out of her own pocket in 5 months. For chemotherapy, she has spent R576 000, but the medical aids have paid back R170 000, reimbursed R170 000.

For planning and tracking scans R66 000, reimbursed R11 570. For surgery R48 000, reimbursed R2000. For consultations with the oncologist thus far R45 000, reimbursed nothing. Blood tests and testing scans R51 000, total

paid back R24 000. Medicines anti-nausea, painkillers, antibiotics R232 000, total paid R56 000.

That is just the beginning of the story. Now that person is in a privileged position in the sense that at least she has that money, well she doesn't, it is a terrible financial strain, but what we are saying to you, is that there are many people who do not have that money and would simply fall out of care and would die as a consequence, so getting this market right, making it fair and equitable, allowing it to continue to be profitable, is really a life and death matter for many individuals, but it is also central to an efficient functioning and constitutional health system in South Africa thank you very much.

JUSTICE NGCOBO Thank you Mr Heywood, I hope you won't run away to answer questions that we might have for you and your colleague.

MS RUGEGE Mark will be here for the remainder of the day.

JUSTICE NGCOBO Thank you.

MS RUGEGE Thank you Chair and thanks to the panel, thanks also to the technical team and the evidence leaders who have guided us through this process up until this point. Chair we have taken the approach in these

hearings for our submission to limit our oral submissions to some highlights. We have been advised to proceed on the basis that our comprehensive written submission of October 2014 is in the record and has been read, so we will not try to address all of the issues in our comprehensive written submission.

Just as a quick outline we will start with the constitutional context and then highlight some of the issues under the headings in our written submission, the first being the pricing of healthcare services. The non-compliance with medical schemes legal framework, the impact of non-compliance on human rights and in particular, the rights in the Bill of Rights in the Constitution and then we would like to raise some recent developments that have happened since we made our written submission in 2014 that we think will be relevant to this panel. We of course will end by tea and hand over to our partners.

So as Mark has indicted in his presentation, Section 27 is the starting point for us and for our partners and we believe for the inquiry itself, the right for everyone to have access to healthcare services is a guarantee in the constitution. The obligations on the State are to ensure that reasonable legislative and other measures are taken to ensure that more and a wider range of people enjoy this right over time. In fulfilling this obligation by the State

in particular, the Government is entitled to adopt as part of its policy to provide access to healthcare measures designed to make medicines more affordable and this is from a case relating to medicines in particular, but we think it is relevant to other healthcare services.

We also as a starting point, consider what is also in the preamble of the National Health Act which is about a unified health system and one of the objectives of the National Health Act which is a key legislation is to ensure greater equity within that health system as a whole and not in one part of the system only. So the National Health Act recognizes the socio economic injustices and imbalances and inequities of the health services of the past.

In some ways, the inequities in the health system are a reflection of the inequities in society and part of the reason why we should be working towards a more equitable health system, is to be part of the greater transformation project of this country. Now while the panel's focus will be on the private health sector, we think it is necessary to understand that it is part of a unified haul aimed at realizing the right of access to healthcare services for all.

In our view as well, this very inquiry is a constitutional measure as described in Section 27 (2) of the Constitution and I will just quote from a recent judgement in the Netcare versus KPMG and the Competition Commission Case in which the Court said that the enquiry is a constitutional measure taken in order to comply with the State's obligations to promote and fulfil that right of access to healthcare services. So we see this inquiry as very much part of this transformation project.

So moving onto what are the obligations on the private healthcare players. Our constitution in some ways, is unique in that it places constitutional obligations on private actors in Section 8 of the Constitution and we would just highlight that at the very least there should be a negative obligation not to impair the rights of users as they navigate their way through the private healthcare system and that is sort of not putting up barriers for people to access and also, a duty on those role players to comply fully with the relevant regulations that are in place, because those regulations are in place in order to progressively realize the right of access to healthcare services. We believe that those obligations lie on private sector actors as well.

The Chair in his introductory remarks yesterday, talked about the

International Convention on economic, social and cultural rights and we would highlight that as well as one of the obligations placed on the State. In Article 12, the Convention states that State parties to the present, convention recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This of course came into force just last year and general comment 14 is relevant to these proceedings as well.

It says payment for healthcare services as well services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services whether privately or publically provided, are affordable for all, including in particular socially disadvantaged groups.

So moving on then to some of the issues that we have raised under headings in our written submission, we talk about pricing of healthcare services and we note some of the research coming out of the Competition Commission that they are high and increasing prices in the private healthcare sector and part of the reason for this inquiry is to inquire into the reasons why.

But the lack of price setting mechanisms leaves patients vulnerable. Those patients must pay the balance of unpredictable invoices not paid by their medical aid schemes. Potential mechanisms for price regulations, should they

be recommended by this panel, should be transparent, independent and involve relevant stakeholders and this is in line with some of the constitutional [indistinct 31:33] which talks about the reasonableness of measures taken by the State which should include these kinds of principles.

As has been said over the last day and this morning, are very concerned about the PMB framework. As you know, these are the provisions that require schemes to pay in full and without co-payment or deductions for diagnosis, treatment and care. Our partners will go into some detail about the experience of some of their members in accessing PMB's.

In our view, these PMB regulations are there to protect the rights of users and any measures that are taken should keep this objective in mind. As is evident from the annual reports of the Council for Medical Schemes, a lot of the complaints of people trying to use the private healthcare system are around the non-payment and short-payment of their prescribed minimum benefits.

Another issue that we covered in some detail in our written submission is the role of the Health Professions Council of South Africa which is the regulator of the health profession. We talked in our written submission about the HPCSA's public interest mandate their duty is to protect the interest of the

public and of the profession. The HPCSA is responsible for addressing any complaints about over-charging by health professionals and also to assist those complainants to navigate the system to ensure an outcome and ensure that they are then able to exercise their rights.

The benchmark for over-charging includes measures in Section 53 of HPCSA Act which are commonly known as the ethical tariffs. As far as we understand, a process that was started in 2012 with all the stakeholders of the health system began a process of trying to re-engage with the ethical tariffs process, but has to-date not been finalized. This is obviously important because over-charging is a disciplinary offence within the HPCSA ethical framework and those health professionals who do over-charge commit both a disciplinary offence but also trample on the rights of users.

So just to talk about violations of rights of users, in our view, the failures to comply with the PMB regulations, which are measures in terms of Section 27, expose people to the risk and reality of aggravated illness placing users under significant physical, financial, emotional and psychological strain and in fact, deteriorating health.

In our view and you will hear from our partners on this, these are serious consequences of the non-compliance with an existing legal framework and we would ask the panel to pay particular attention where violations of rights are found. We submit as well that the short payment of PMB's do amount to violations because of the consequences on individuals. You will hear some stories from our clients who have had to in fact choose whether to obtain health services or not obtain health services, because they were not able to get cover from their medical scheme, even though they were entitled to that cover.

We also, I might just add, have prepared for public consumption and for the panel, some stories of people that we have dealt with and who we have assisted by navigating the private healthcare system with them and very often we found that the mere involvement of lawyers, is the trigger to get cover for people, because very often, it is a very clear violation of the regulations and a mere involvement of Attorneys or threats of litigation will ensure that people are able to access the care that they require. So please note that this is available and we hope to place it into the record of this inquiry.

As I said, we would like the panel in its report and recommendations to

highlight the specific rights violations and this we think will help to educate the public about what kind of conduct by the industry players, amounts to rights violations. We think that this public hearing is an important tool for public education so that people understand how the system works, what they are entitled to and how to navigate the system and indeed, if there are violations of rights, how to address those violations. So we would ask that the recommendations of this inquiry reflect that.

Chair I would now like to address some of the more recent developments that have happened in the last year or so. I will pause for questions if there are questions in relation to what is in our written submission, otherwise I will address some new material.

JUSTICE NGCOBO Well unless my colleagues have questions to put at this stage, perhaps you should, proceed and then we can deal with the questions at the conclusion of the submissions, unless of course they do have questions that they want to pose at this stage.

ADV PILLAY SC Chair I just have one question. Ms Rugege you make your submissions on PMB's in relation to the regulations and not in relation specifically to the code of good practice on the handling of PMB's. Perhaps

you could address your views on the code and whether what is needed, is to give teeth to the code to ensure monitoring and implementation.

MS RUGEGE Thanks Kameshni,I think the code of good conduct was raised in yesterday's presentation. Our understanding is that this has never been part of the legal framework so it was not something that was gazetted. It is more of a guide, but in our understanding, it is not even as a guide, being implemented. We understand that the process that drafted those codes, never reached a final conclusion and perhaps we can hear from the Council for Medical Schemes on that. The code of good practice is relevant, I think it is a few years out of date at this stage and require a re-look at the code in its entirety, but it does have some very good information and guidelines, for example, it talks about emergency medical treatment and that is an area that is unregulated within the private health system and to some extent, in the public system although we have just had some draft regulations put out by the Department of Health on emergency medical services and emergency medical treatment.

So we think that there are a number of avenues to address the issues in the code itself, but I would say that we need to re-look at it, given that it has been

a few years since it was drafted, so that would be my response.

JUSTICE NGCOBO What is the status of this code?

MS RUGEGE For me, it is unclear what the status is, as I said it was not published in a final form by the Council for Medical Schemes nor was it gazetted.

JUSTICE NGCOBO What is the statutory basis for the code if any?

MS RUGEGE Well I believe within the Medical Schemes Act, there is space for consultation between the Council for Medical Schemes, the regulator and the stakeholders to put in measures to properly address issues of complaints and so on. I can find a provision within the medical schemes for you, but there certainly is room within the Act for that kind of consultation and the development of a code of good practice

JUSTICE NGCOBO I understand that, but I think what I was looking for, is, is there a statutory authority to develop the code and if so, what is the status of the code in relation to those who use the services of the medical schemes? Is it binding on them or is it no more than a guide?

MS RUGEGE Chair I will have to come back to you perhaps in the tea break, but I believe that it is a guideline.

JUSTICE NGCOBO Yes very well thank you.

MR SELEKA Sorry I've got 2 questions of clarity for Section 27. One of the questions relates to PMB's and the other to the obligation that arises from Section 27 of the Constitution. On PMB's in so far as there is a concern regarding short-payments and non-payments, I don't know whether you've had regard to the provisions of Section 8 of the Medical Schemes Act in terms of which the schemes are permitted in their rules, to provide for the following. So the rules of the medical scheme may in respect of any benefit option, provide that the diagnosis, treatment and care costs of the prescribed minimum benefit condition, will only be paid in full by the medical scheme if those services are obtained from a designated service provider.

Or there could be a co-payment or deduction, the quantum of which is specified in the rules of the medical scheme which may be imposed on a member if they do not use a designated service provider. How do you deal with that aspect in regard to your concern for non-payments or short-payments? That is one question.

Then on the Section 27 obligation, in your submission you said there is at least a negative obligation on the parties in the private healthcare sector. The provision imposes a positive obligation. Do you think that is also imposed on the private healthcare role players or stakeholders?

MS RUGEGE On your first question, indeed when we talk about full payment of PMB's we are talking about those cases in which patients have gone to a DSP. The provisions in Regulation 8 that you read out, are meant to give the medical schemes a way to manage their liability which we believe is correct, so the medical schemes will negotiate with a designated service provider and agree on fees and so on and will send their volumes of members to say the Netcare Hospitals or to a network of specialists or to a network of pharmacies.

So we accept that those provisions are in place and that patients should and we advise them to go those DSP's. However, some of the schemes avoid liability by not designating service providers and then requiring their members to go to the public sector. In fact, the case that I am going to talk about shortly, is related to that issue, where the scheme instead of designating a service provider in which they then have all their members go and negotiate

prices with those providers, will avoid liability altogether and say well we haven't designated a service provider. We think that is a problem, but we do accept that medical schemes must have a way to manage their liabilities. I hope I have answered your question.

I wasn't clear on your second question about the negative and positive obligation, if you could please repeat that?

MR SELEKA I think in your presentation you said that the parties in the private healthcare sector at least have a negative obligation not to impair the right of the consumers to access private healthcare. So my question is in so far as the section, that is assuming that you accept that it imposes a positive obligation and I think you did say in so far as Government is concerned, what would you say about a positive obligation in the private healthcare sector, or do you simply adopt the view, do you simply hold the view that all that is imposed in the private healthcare sector is a negative obligation? So they don't have to impair, but are they at liberty not to offer the services?

MS RUGEGE I understand the point. I think as I referred to in Section 8 of the constitution, there is a provision that imposes constitutional

obligations on private actors and as it says, that duty has to take into account the nature of the right and the nature of the duty imposed by the right. So I think one would have to engage with that provision in relation to the private healthcare and the particular players and their business within the health system to understand what the positive and negative obligations are.

I think Section 8 (2) does not refer to a negative or positive obligation and therefore we would not limit our submission only to negative obligations.

MR HEYWOOD Can I just add to that, I think we would say that when it comes to the private sector, that there is at least a duty to respect and protect the right and not to behave in a way that unreasonably infringes on the right of access to healthcare services and the question is what is unreasonable. When we went before the Competition Commission many years ago on the access to antiretroviral medicines, we didn't argue against the notion of intellectual property protection per say, but what we argued was that market exclusivity was being used to unreasonably inflate prices of medicines to a level that made them unaffordable to people who needed those medicines which had consequences on human health and dignity and we tried to show that there was no relation between what was the inputs that went into those

medicines, the research and development and the actual price, so it was an abuse of the market, that was certainly an argument that we made then, but of course a settlement was reached before the Tribunal pronounced.

We will also say though that there is and I don't think there is any dispute about this, but there is a positive obligation on the Government to take measures including measures in relation to the regulation of other parts of the healthcare system, the private healthcare system to ensure access, it is a duty that under Section 27, there is a duty to take reasonable legislative and other measures to ensure access to healthcare services, so if the Minister of Health sees that there is an unreasonable pricing of health services or medicines that is impeding access and that is having consequences on the broader system as a whole, then he doesn't have a choice, he has a duty to institute measures to try to rectify the imbalance.

MS RUGEGE I hope we have answered your question.

MR SULEKA Yes if I may take you back to the PMB's, did you say that the schemes are refusing to pay in full even when a member has gone to a designated service provider?

MS RUGEGE I gave an example of a scheme's refusal to pay when the scheme had not designated a service provider, so had not taken the step to say you must go to a Clicks Pharmacy in order to get your medicine and so the patient then went to any pharmacy and was told no we don't pay, that was the conduct of that particular scheme.

MR SULEKA Okay thank you.

MS RUGEGE So I've started to talk a little bit about Genesis Medical Scheme versus the Minister of Health and just as an outline, there are 3 things I would like to discuss. That is the one case. There was also in 2015, an investigation into the failures at the HPSCA and lastly, there is a proposed amendment of the PMB regulations Regulation 8 which I would just like to draw the panel's attention to.

So Genesis Medical Scheme launched an attack on the Minister's powers to make provisions in Regulation 8 related to the payment in full for PMB conditions. The Genesis Medical Scheme viewed Section 67 of the Medical Schemes Act as restricting the Minister's powers mainly to provide a list of PMB's, so Genesis accepted that the Minister may put in place the twenty

five chronic illnesses and the many other treatment guidelines that form part of the PMB's.

However, their interpretation of Section 67 was that the Minister could go no further by requiring any kind of payment of those PMB's. This is an ongoing case in the Western Cape High Court. We were in Court in 2015 intervening as [Amica Curiae] on behalf of the Treatment Action Campaign, the South African Depression and Anxiety group and people living with cancer, all of whom had an interest in this case and many other groups will have an interest in the case because it goes to the very heart of the PMB framework.

Other intervening respondents were the Hospital Association of South Africa, the Council for Medical Schemes and its Registrar, the South African Private Practitioners Forum and Multiple Sclerosis South Africa amongst others, all of whom intervened as respondents in this matter.

Judge [Bleno] of the Western Cape High Court gave a ruling allowing the intervention of all the parties including the [Amica Curiae]. That judgement was taken on appeal by Genesis arguing that Judge [Bleno] had in error, allowed the intervention particularly of the intervening respondents all of

whom have a very key interest in the interpretation of the powers of the Minister in relation to Regulation 8.

Genesis is now in the Supreme Court of Appeal. They did make application to the Constitutional Court which was rejected. There is now an appeal at the SCA. This matter is pending. We hope to be able to make submissions on the merits of this matter before the end of this inquiry, but in any event, the interlocutory judgement is on appeal.

JUSTICE NGCOBO From what you have described, it is a procedural matter isn't it at this stage?

MS RUGEGE At this stage it is a procedural matter yes.

JUSTICE NGCOBO The Courts haven't dealt with the merits have they?

MS RUGEGE No.

JUSTICE NGCOBO And it is far from dealing with that at least at this stage?

MS RUGEGE At this stage no, unless the SCA speedily deals with the appeal. I just wanted to highlight one issue from the judgement by Judge

[Bleno]. He recognized the very public nature of the case and said the relief would probably also affect the availability of healthcare services to many members of the public and that is one of the reasons why he allowed everyone who was interested, to intervene in the proceedings.

The Ministerial Task Team which was set up by the Minister of Health conducted an investigation into alleged maladministration, irregularities, mismanagement and poor governance at the HPCSA. We have an executive summary of the three hundred page report which was provided to us on 25th October 2015. The findings include the delays in professional conduct complaints and many other issues around the management and governance of the HPCSA. The MTT also recommended disciplinary action against the top officials within the HPCSA for the failures, what they called multi-system failures within the HPCSA and recalling that this is an important regulator within the private health system, we wanted to draw to the attention this comprehensive report of which we have given the panel, the executive summary as one of our exhibits.

Lastly Chair just to…

JUSTICE NGCOBO I wonder are you in a position at this stage, to just highlight what you think are the key points that, are relevant to this inquiry?

MS RUGEGE In the HPCSA?

JUSTICE NGCOBO In the Ministerial Task Team Report.

MS RUGEGE Chair I think one of the key things in this report of which we have only seen the executive summary there are 4 major findings of the investigation. First there was evidence of administrative irregularities, mismanagement, poor governance at HPCSA which was documented in a forensic investigation by the KPMG in 2011 on the procurement procedures followed for the IT system.

This involved the COO and the CEO who is also the Registrar and also implicated the legal services. It also highlights that there have been a lot of anonymous complaints about the HPCSA by whistle blowers within the HPCSA itself as well as from external stakeholders, so they have been a litany of complaints that were not addressed adequately by the HPCSA and that came out during the investigation.

JUSTICE NGCOBO Does it deal with the regulatory powers of the HPCSA and does it address the question whether or not those powers or functions have been properly carried out by this regulatory body?

MS RUGEGE Chair unfortunately we don't have the full report, so we can only give you highlights from the highlights I am afraid. As far as I understand, from what I can see, this was more of a factual investigation into the complaints. I am not clear that the regulatory powers of the institution were dealt with, but they may well be dealt with in the full report.

JUSTICE NGCOBO Okay very well thank you.

MS RUGEGE May I just add another highlight from the report, recommendations for the institution of disciplinary proceedings against the Registrar who is also the CEO, the COO and the General Manager of legal services, all of whom are basically the top management of the institution, which shows a clear failure in the leadership of the organization.

We also see that there is a recommendation for the appointment of an interim management team which we believe has not taken place yet. There is also a recommendation for a more detailed review around the governance structures

and administrative structures of the HPCSA.

Also there are complaints about how bureaucratic and bulky the whole structure is and perhaps there is a need for streamlining of the existing governance structures to ensure greater efficiency within the HPSCA.

MR HEYWOOD Chairperson could I add just a little bit, which is just to say that underlying our argument, is the belief that the full and proper functioning of these regulatory bodies and oversight role that they are meant to play in both the private and public sectors, is absolutely essential to the smooth working of the markets and the HPCSA's responsibility is with the admission, with the practice, with the ethics of registered doctors and if its systems are not working, then it denies the patient recourse and anecdotally, we get many complaints from doctors as well as from patients that there is just a bureaucracy that is unresponsive, that doesn't take complaints forward.

I mean we can happily provide you with evidence if you wanted it on some of those things, but it is vital that these bodies are funded sufficiently, that they have budget and that they have a quality of management that allows them to fulfil their statutory responsibility within this market.

MS RUGEGE Just lastly, there has been a draft amendment proposed by the Department of Health that will amend Regulation 8 and effectively has the effect of capping the liability for medical schemes for PMB's. The proposal and the gazette is in the pack that we provided, refers to the National Health Reference pricelist which was last published in 2006 as a benchmark for the cap on payments by medical schemes for PMB's, adjusted for CPI.

We raised concerns about the proposal because we think it is retrogressive in that it introduces co-payments where patients currently don't have co-payments and also, it is rather outdated. It is a rather outdated benchmark for a starting point.

So we raise this to say that we think that these kinds of proposals will benefit greatly from the outcomes of this enquiry. The information and analysis that has been done by the Commission and by the Technical Team we hope will be made available to the public generally, but certainly to the policy makers. We think that it is the kind of evidence that will bolster policy interventions and ensure that those policy interventions are evidence based and so we are very pleased that this inquiry is happening at this critical time.

PROF FONN Can I, just put before you, a question in relation to the proposed changes? This happens in the context of potential supplier induced demand and in the context where the knowledge as to what works as an intervention is not clear. There is significant both asymmetric information, but also imperfect information, so I am not suggesting that people act cynically, but they are acting in a way, where we really don't know what works and certainly for patients, this creates a huge problem because they in instances, might under-consume where they should be having interventions that they need, but they might also over-consume where they are hopeful and sometimes blindly hopeful, so they will consume things even where the evidence is that they don't really work or prolong quality of life.

So in that instance, it could also be argued that the Minister's intervention is to place on limit what is available, because sometimes what is available, might not be rational and so how do we resolve this issue, because it seems to me that it is a very complex issue, allowing limitless consumption would ultimately result in increased cost of being a member of a medical scheme and thus decreasing access and then that has to be balanced against unreasonably withholding and how do we resolve that sort of issue, because it

doesn't seem to me to be one that there is an immediate answer to in my mind.

MR HEYWOOD I will start and just do my best to answer what I think is a crucial question. I think the strange situation that we have at the moment, is epidemic under-consumption in parts of the health system of what is needed for health and for treatment and anecdotal suggestions of epidemic over-supply and consumption in other parts of the health system and that the overall lack of transparency information makes it very difficult to strike that balance that you are talking about and that is why again, one of the arguments that we would make before you, is just that there should be a duty to provide much more information both into the system about cost, but also about benefits.

I think a lot of people walk into and I think even empowered people, walk into private health facilities and walk out forty five minutes later carrying a bill of R6000 or R10 000 and don't feel able to question how does this add up. You have been exposed to some sort of new technology, but you don't know whether you are being ripped off or whether this is a fair charge. People are completely disadvantaged, but what we would say is that we are

not and I don't think anybody would argue for limitless consumption of access to medical healthcare services. It is accepted that there has to be rationing. I mean that has been accepted as far back by the Constitutional Court as the Subramoney case that there has to be some sort of rationing and not all people will be happy with rationing.

Some people will suffer from rationing, because the resources are not limitless, but it is possible to ration on the basis of evidence, on the basis of best practice, on the basis of medical knowledge and the continual evolution of medical knowledge, that is not what is happening at the moment.

The final thing I would say on this though, is again linked to the fact that resources are not limited, when people are over paying for healthcare services, then the money that is available for health goes on fewer people than if they were paying properly, fairly, reasonably for the healthcare services, so again we would say there is a constitutional duty on the Minister to make sure that people are paying fairly because then the same amounts of money will actually go to more healthcare services, both at an individual basis and at a collective basis, so one of the characteristics we have of this market which is again evidence that it is skewed, is that the level of out of pocket payments,

so primarily people who think that they are insured their medical aid schemes, their medical schemes run out of money, they are still paying a few thousand rand a month even when they have run out of money, but now they are taking directly out of pocket.

I don't have the latest figures, but the out of pocket expenditure on healthcare services the last time I saw it, was in the region of R20 billion per annum which is a huge cost on the consumer of healthcare services and is not a neutral cost because it then has a knock-on effect exacerbating poverty because somebody has to take from here to put into there when it comes to the healthcare, but really we are very alive to the fact that resources are limited and it is not about a question of just the sky is the limit when it comes to, that is not what we are going for public or private.

JUSTICE NGCOBO When you are talking about the resources being limited, where, in the private sector or in the public sector?

MR HEYWOOD Both, for myself for example as somebody on a medical aid scheme, my resources for health and my family are limited by what I can afford on a month to month basis, on whether it meets my needs. When it comes to the public health sector, the resources are limited by the

budget that is allocated by the Treasury to health which is based on a calculation of how do, we meet the health needs of the people of the country and if you go over budget, there is not money and that is what we are seeing.

But again part of the problem is this lack of cognizance or the intersection between public, so there is one market, but two silos. Sometimes the public could benefit from access to resources that are in the private. Sometimes the same private in the same circumference of a suburb, you will have two big private hospitals each with MRI and CT scans and so on, so like I said earlier on, there is an anarchy that the consumer or the person who needs healthcare pays the price for.

PROF FONN Can I clarify the retro-gressiveness in relation to the proposed changes to the medical scheme act is, am I understanding you correctly, that you are saying that it is because it is stepping back from the notion of payment in full and is that predicated on your belief then that the 2006 National Health Reference price list plus CPI, would be too low a bench?

MS RUGEGE I agree with that. Firstly, the retrogressive comment that I made, was in relation to people's current access, so where for example a

person's chronic medications will be covered or a certain number of visits to their GP, if they have a particular condition, they currently get that access because they have the cover. If they then have to choose between paying school fees and paying for the medical cover because now the cap is much lower than what the actual invoice is, then we will see situations where people no longer have the healthcare services that they currently have.

We consider that to be retrogressive based on the access, but also the 2006 NHRPL plus CPI is probably I am not an economist so I can't really comment on that, but what we do see on the evidence, is that medical inflation is higher than CPI every year. We may even have a chart here in this booklet that shows the difference between medical inflation and CPI. Also the 2006 NHRPL will not include the developments in medical care and techniques and treatments and diagnostics that have occurred since 2006.

PROF FONN I just want to explore this one step further and that is that this ruling could give the schemes who are supposed to be representing the interests of their members, muscle in arguing with suppliers that they have to bring their prices down and thus bring down costs.

MS RUGEGE Well they already have that power. On a regular basis, what the administrators do is they negotiate and they have bargaining power with their suppliers, whereas if the cap was to impose a limit, then there might be an impact on that negotiation as well.

DR BHENGU Thank you, you made a case for regulation of pricing in the industry and I just want to be sure I understand when you say the HPCSA must complete the process that started by determining and publishing ethical tariffs, I just want to understand especially in determining what you mean by that before I proceed?

MS RUGEGE What we mean by what sorry?

DR BHENGU By determining, you say determine and publish ethical tariffs, by determine what do you mean?

MS RUGEGE So what we mean is that determine through a process and that process has not been completed, so there were consultations with stakeholders about the mechanism itself to determine those ethical tariffs, but that process has not been completed.

DR BHENGU By determine, do you mean that the mandate of the HPCSA as it stands basically requires that the Council starts from scratch in working what the actual tariffs should be, or are you saying this necessarily follows what you already recommend, that industry must determine whether through collective bargaining mechanisms or any other mechanism, because one could see that as the other way where there is a process determining the tariffs which then feeds into the Council's pronouncement at which point do those tariffs become unethical? Now this is where I am getting lost, because I am seeing you making reference that the HPCSA must determine and publish, but elsewhere you also support the process where the industry determines tariffs.

Now I am not sure if you are proposing 2 potentially conflicting processes or you are saying one after the other?

MS RUGEGE At this stage, what we were saying is that there are many processes underway within the private healthcare system and we see this inquiry as a potential way to assist those processes to determine the mechanisms that are the most appropriate, methodologies, that would result in a mechanism by providing the evidence that we have not seen before about

the bargaining power, collective bargaining kind of, we will hear from the OECD about the kinds of collective bargaining probably that happens in other countries, so we at this stage, cannot recommend a mechanism or the order of mechanisms.

What we are saying at this stage, is that given that there are many attempts to try and address the issues within the private healthcare system, this inquiry is timely in that it will provide support to those processes and help to see them to the end.

DR BHENGU I suppose in closing maybe let me just try, another way. Do you feel that most of what needs to be done in determining what are, the appropriate tariffs should be, should lie within the Health Professions Council as a body that should be responsible for determining tariffs?

MS RUGEGE Not necessarily, I think what we are saying is that there is a particular duty on the HPCSA which comes from the HPCSA statute that requires them to deal with over-charging. Now if we at the end of this inquiry, there are recommendations around other kinds of price regulation or guidelines or tariffs, then it may be that HPCSA can rely on that mechanism rather than having 2 separate mechanisms, but at this stage, we have neither.

DR BHENGU Okay I think you have covered what I wanted, but it looks like Mark wants to add?

MR HEYWOOD Just a very brief addition to supplement what Umunyana said. I mean obviously the HPCSA as a statutory body only has responsibility for registered medical practitioner which are just one part of the jigsaw of the private healthcare system where you have a problem of prices that appear to be out of control, so it does need to be addressed through there, but we would still argue that actually what you need, the primary duty lies with the primary duty of the holder when it comes to Section 27 right of access to healthcare services in this country which is the Government to take measures which are reasonable measures and clearly in everybody's interest and that's where we would look for action, for some sort of holistic approach.

Part of the problem in the past, has been this fragmentary approach where you try and deal with this problem, but leave this problem untended and it doesn't sort the systemic difficulties out.

DR BHENGU Thank you.

JUSTICE NGCOBO I wonder if you could go to your recommendations so

that we can then put questions thereafter?

MS RUGEGE Okay I had initially skipped over the general recommendations made in our written submission to come to what we calling the post inquiry recommendations if that is all right. So what we have suggested also in our written submission is some kind of post inquiry structure or guideline to take forward the panel's recommendations and we think that the involvement of the Commission should not end in December 2016 when the panel's report is published.

We would also urge for an indication of the most urgent recommendations and particularly where there are rights violations implicated, that those are in particular highlighted. We would also propose for a time line for the implementation of recommendations although we understand that where there are other institutions involved, those will not be accurate timelines but a general recommendation around that.

Also perhaps guidance to the Competition Commission at about how to publicize the report of the panel and how to continue to engage the public and continue with the public education about what the findings of the inquiry

have been and how those will impact on members of the public, so we are hoping to see that also as part of the post inquiry actions.

That brings us to the end of what we prepared. We are here for questions.

ADV PILLAY SC Just a question around the question of this recommendation of price regulation. We noted that you look at the duty to effect price regulation at the level of either the Minister or the National Department and located within the context of Section 27. Does this recommendation then stand independent of a finding within a competition context that there has been market failure or not?

MS RUGEGE No I wouldn't say that. I mean as we said in our presentation today, the primary duty bearer would fall with the State in particular, but not only with the Department of Health, so we are not suggesting that there should not be mechanisms that are located say within the industry itself. We certainly recognize that there is a possibility that such recommendations could be made and would not necessarily fall under the prevue of the National Department of Health or any other department.

ADV PILLAY SC The real question though is, would that

recommendation depend on a finding that there has been market failures within a competition context or not if it is located within Section 27?

MS RUGEGE No we don't suggest that there would have to be a particular finding of market failures. What we are suggesting is that the duty that falls on the Minister of Health and the State broadly stands independently.

MR HEYWOOD Can I just add to say that the word price regulation might suggest a bit of a blunt instrument as well, because we wouldn't claim to be experts in mechanisms for price regulation, but if you look at what happened with medicines, the Ministry had the objective of creating downward pressure on the price of medicines in order to make them more affordable and accessible in both the public and the private healthcare sectors, so they had a range of avenues that they could do that and they didn't in fact involve direct price regulation. It partly involved introducing generic substitution taking advantage of international law, there are various things but what we believe you may find differently, is that price escalation which there is much evidence points to a failure of the market and points to the lack of controls on this market that has consequences for people and that there should

be an endorsement that is reasonable and of course we keep stressing reasonable measures because we don't want to get into another 10 years of litigation around whatever proposals come out of this.

Reasonable measures that keep competition alive, but act in the interests of the consumer, of the patient, that are entirely within the power of the Department.

DR BHENGU Last one from me. Just picking up on your well-argued case on access that you did to come back to access, link that to the barriers of entry issues that we need to deal with, but also tied back to your reference on Paragraph 48 about rights of professionals. You make reference that healthcare professionals have the right to practice their trade. My question is does that right in your understanding, extend to professionals having a right to practice where they want? I am obviously addressing the certificate of need, because that is central to the barriers of entry issues, central to the access issue. What is your view of this?

MS RUGEGE Well we did include that discussion about professional rights to practice your trade in our submission and we also talked about the balancing of rights, so for example, one has the right to practice their

profession, but there can be imposed requirements such as you must have a certain qualification, so it is not an unfretted right, but we also, what we have said in our submission is that there must be a balancing of rights as well and I think one should also take into account in relation to the certificate of need and particular what the broader policy objectives are in the National Health Act and as I understand it, the provision was brought into force and then not taken out of force again through that process, so the certificate of need is not a legal requirement at this stage.

However, we think that in terms of access and [Dagan] from the Rural Health Advocacy Project is going to talk in particular about access in rural areas and I think will address this very issue, so I will allow him to respond, but just to say that there are broad policy objectives around access that must be balanced.

DR HEYWOOD I would also suggest that maybe the Commission takes a step back in the way that it addresses this question of right to practice where you want, because we have heard that argument lots of times and the suggestion that if you have a certificate of need that tries more to allocate equitably health services and health professionals that it is a violation of the

right for association or whatever, but actually the so called right to practice where you want at the moment, is possible, partly because of the uncompetitive practices of the, the fact that the industry is shielded from competition, so I can say well my right to practice where I want, means that I will practice in Four Ways where there is already 5 big private hospitals which is affluent and over-serviced and so on and so on.

The way the industry is conducting itself, means that I am shielded from the normal things. If it wasn't possible for me to go in there, because the system didn't allow over-population of services in particular areas, then I would be forced to go like many other people do in the job market and seek to practice my profession or set up a clinic or a hospital in another area, so I think you have to look behind that question as well.

MR SELEKA There is one particular question which this inquiry is interested in, particularly in regard to members who belong to medical schemes. I don't know whether the question will be answered by you, or probably your witnesses, is the role played by the brokers in the relationship between the medical aid scheme and its members, whether your members are

given information in regard to how PMB's are applied.

MS RUGEGE Sorry did you say brokers?

MR SELEKA Yes.

MS RUGEGE I think we will leave that to our partners to address.

MR SELEKA Okay.

JUSTICE NGCOBO You drew attention to Section 8 of the Constitution which provides essentially that the provisions of the Bill of Rights apply to natural persons and juristic persons to the extent that the nature of the right permits it to do so. Now what is it that you say is in the nature of the right of access to healthcare which makes the provisions of the Bill of Rights applicable to private players?

MS RUGEGE I think firstly, the nature of the right is about life and death and I think that that is an important thing to repeat in answer to your question. I think that in many cases, people's health may deteriorate as a result of not gaining access and they may be unable to have a fulfilling life and to reach their potential, so health is really at the core and is very much

linked to the right of dignity as well in the way one is able to access those services.

So that's to say the nature of the right is inherent in a human being, but also it is a right that is practiced uniquely within commercial industry and so on the one hand, we have a thriving industry where we see high profits and on the other hand, we have individuals who must navigate this commercial landscape in order to be able to realize their rights.

MR HEYWOOD I can only add a little bit to that which is as we said that Section 27 rights comes up in a whole number of other rights and the Bill of Rights with different language whether it is in relation to children or prisoners or bodily or psychological integrity. As Umunyana said, we think that equality is very critical. Again if you consider the thinking behind the drafting of the Constitution, how inequality and access to healthcare services was so much a characteristic of the past and then it is also linked to rights like privacy which is very fundamental to access to healthcare services as well, so we are arguing that if you look at all of these things together and this is a very different type of market to a car market or a perfume market or something like that. It has very direct bearing on the lives of every single person who

resides in South Africa.

JUSTICE NGCOBO The National Health Act of 2003 is a statute which was enacted to give effect to the provisions of Section 27 of the Constitution, is that right?

MS RUGEGE Yes.

JUSTICE NGCOBO Mr Heywood made reference to the interface between the private healthcare sector and the public healthcare sector. Now Section 45 of this Act deals with the relationship between public and private health establishments in particular it requires the Minister to prescribe mechanisms to enable a coordinated relationship between private and public health establishments in the delivery of health services. Do you know whether those mechanisms have been put in place?

MR HEYWOOD I don't think that those mechanisms have been put in place, or that they have been put in place sufficiently. There are other parts of the National Health Act that have bearing on this, for example, that there is meant to be district health plans in every district, there is meant to be district human resource plans, which again given the provision that you've pointed

out Justice Ngcobo, suggests that when you look at provisioning for a district, then you should look at all the health resources within a district and attempt to coordinate them and my sense Justice Ngcobo is that is part of the thinking that underlies the future National Health Insurance Scheme although clearly there is a long way to go before we get to that point, but I may be wrong, but I am certainly not aware of mechanisms that play a role in directly coordinating the relationship between private and public establishments in the delivery of health care services.

There are bodies like provincial health consultative forums which don't take place in most provinces in a meaningful way. There are forums like the National Health Consultative Forum which I have to say doesn't really take place in a meaningful way, so perhaps there is space for better engagement, but I don't think it is being done expressly.

JUSTICE NGCOBO You also raised a concern about the price regulation. Now Section 90 of this Act empowers the Minister to make regulations in particular Section 90 Sub Section 1(v) which contemplates that there will be regulations dealing with the processes of the determination and publication by the Director General of one or more of reference price list for services

rendered, procedures performed and consumable and disposable items utilized by categories of health establishments and health establishments includes hospitals as I understand it.

Healthcare providers or health workers in the private healthcare sector which may then be used by a medical scheme as a reference to determine its own benefits and two, which may be used by health establishments, healthcare providers or health workers in the private health sector as a reference to determine their own fees but which are not mandatory.

Do you know whether those regulations have been made?

MS RUGEGE We understand that this was done. However, in a case with the Hospital Association of South Africa in 2010 in the Gauteng High Court, that process was set aside on the basis that these regulations were not properly complied with, so there has been an attempt to use these regulations by the Department. However, that attempt was challenged and was set aside in that I can get you the citation Judge. It is the HASA Case 2010.

JUSTICE NGCOBO Are you suggesting that this regulation is inadequate to address your concern about price regulations?

MS RUGEGE We haven't suggested that these regulations are inadequate to put in place a mechanism for regulation of prices. However, the regulations, these broad regulations provide the Minister with the powers to engage in that kind of process. We don't suggest that this particular provision in the National Health Care Act is inadequate and we haven't seen a further attempt to use these regulations, so we haven't seen what other challenges [indistinct 1:44] that attempt.

JUSTICE NGCOBO Perhaps I misunderstood what your submission was. I understood your submission to be that lack of price regulation leave users of the private healthcare system vulnerable, which to me suggested that what you are saying is that there is no regulation, so that is why I wanted to find out whether this provision is adequate and if it is not adequate, to what extent is it not and what needs to be done to make it adequate? In other words, does it matter that there is a rider which says these are not mandatory?

MS RUGEGE What we have said is that Section 90 provides as basically a tool, it doesn't provide for a mechanism and that mechanism would have to comply with this and the Constitution and other provisions of law. So we are not suggesting that the provisions in Section 90 themselves

are inadequate, but we are suggesting that there is a need for some kind of price setting for the protection of our patients.

JUSTICE NGCOBO Pursuant to this regulation?

MS RUGEGE Yes.

JUSTICE NGCOBO Which is adequate?

MR HEYWOOD Justice Ngcobo I think it is very difficult to make it mandatory but of course the panel will have to discuss that. Our view has been that until the HASA case knocked out the Department's efforts to set the National Health Price Reference List which if we were their advisors, we would have told them they should have appealed, but there were efforts, but again, it is efforts in parts of the market and not in other parts.

If they were as envisaged here, referenced price lists or services rendered, procedures performed, consumable and disposable items, then it would certainly be a help in reducing the information asymmetry that we are all concerned about and the lack of transparency that makes people float in a world where they have no knowledge about whether the prices that they are charged are reasonable and are fair prices. It may not be sufficient, but I

think together with other mechanisms as we said earlier on, there are various instruments that are available to the Government, including what is envisaged here that could play a part in this unique market.

JUSTICE NGCOBO I understand that. I am asking this question because one of the concerns that have been expressed to us is that there is a lack of regulation when it comes to matters of pricing. The other is that yes, there are regulations, but they are inadequate. The third category is that yes, you do have adequate regulations, however they are not being implemented, so what I am really trying to get at, is in so far as your submissions are concerned, where you fit into these 3 categories? But you don't have to answer that question now. You may defer to a later stage when we have heard the others of your colleagues if you don't have an answer now, because I just want to get a sense of are they adequate and if they are adequate, then we move on. Are you happy with the way they are being implemented? If not, what are the problems precisely? Do you understand that?

MR HEYWOOD Chief Justice we will discuss this during the tea break and think a little bit more, but I would say to you that our initial answer is that it is a bit of each 3 to be frank. There are areas where there is a lack of

regulation. There are areas where there is some regulation, but it is not adequate and there are areas where we have tried to say with the HPSCSA, there is regulation but there is not proper implementation of the regulation and we need a much more uniform approach where each part works in sync with the other part towards the overall objective of Section 27, but we will maybe come back.

JUSTICE NGCOBO That will be very helpful indeed, because I do think that one of our tasks is going to be when we receive submissions complaining about the regulatory framework. We need to understand precisely what is the complaint about that? Is it because there is a lack of regulation, or is the complaint limited to its inadequacy, or is it only limited to its implementation, so that when we do find a solution, we are on target, as opposed to looking everywhere for an illusive answer.

Regrettably we have cut deep into the tea break.

DRS VAN GENT Just one clarifying question, when you refer to your recommendation on regulation of prices, when you refer to price regulation, you refer equally to regulation of prices of medical specialists and doctors and of hospitals. Do you take them separately or together, because the

conditions in both segments of the market are clearly very different with four thousand medical specialists, 4 groups of hospitals negotiating, so how do I read your recommendation in this respect?

MS RUGEGE I think we refer to both segments of the sector, so we do refer to hospitals and we do refer to specialists and we do so in particular because the information that we have, gleaned from for example the Council for Medical Schemes annual reports, make that distinction and look at the money spent both on specialists who operate within hospitals, but also the costs within hospitals, so it is both.

JUSTICE NGCOBO There is another provision of the Act which I had in mind and that is Section 39 of the Act that I have been asking you about and that is the National Health Act. Now this is a section which empowers the Minister to make regulations relating to the certificates of [indistinct 1:53] and that is Section 39. In particular, Section 39 (2) (f) which says the regulations that are made under this particular section, must seek to avoid or prohibit business practices or perverse incentives which adversely affect the cost or quality of healthcare services or access of users to healthcare services.

Now I haven't heard you refer to that. You are aware of this section are you not?

MS RUGEGE Yes.

JUSTICE NGCOBO Have you applied your mind as to how we might approach this or what it means?

MS RUGEGE We haven't specifically applied our mind to this section in relation to the inquiry, but we are happy to do so.

JUSTICE NGCOBO Yes very well thank, perhaps you may want to reflect on that and then we can see how we can address that. Now to members of the audience, we have about 5 minutes of tea break. What shall we do? This is a consultative process. Your silence means we are at liberty to make a ruling as we see fit. We think we will allow the usual thirty minutes until 12:00 and then we will resume thereafter and if necessary, we may have to run late. We apologize to those who are anxious to take the stand, but we will get back to you as soon as we can, so can we then take a tea break and come back at about 12:00.

[END OF FIRST SESSION]

[START OF SECOND SESSION]

JUSTICE NGCOBO Perhaps for the record, would you indicate who is there, or are you going to follow the program?

MS JANKELOWITZ We are going to follow the program and we are sitting in order.

JUSTICE NGCOBO Okay very well thank you so much indeed, so if you could just state your name and your affiliation for the record and then we move on?

MS JANKELOWIZT My name is Lauren Jankelowitz I am the CEO of the Southern African HIV Clinician Society. I am going to start by just telling you a little about the organization and who we represent. We are a non-profit membership organization of over three thousand healthcare workers with an interest in HIV in South Africa and additional healthcare workers throughout the Southern African region.

Our mission is to promote evidence based quality HIV care in Southern Africa. Our membership includes doctors, nurses, pharmacists and other healthcare professionals working in the field of HIV. We in South Africa,

have a 50% public private split as far as clinicians go, doctor clinicians. The society strives to support and strengthen the capacity of its members to deliver high quality evidence based HIV prevention care and treatment through our range of programs.

We are here today to represent individual members, so individual doctors that often contact us for assistance with private healthcare issues and there are a number of issues. In our written application, we focused on 5. The first is the administrative process. Our doctor members regularly experience challenges with the coding for claims with medical schemes where the medication associated with HIV prevention is not covered by the schemes and only treatment related medication is paid for and this often creates a conflict, because doctors don't know how to code and if they code incorrectly, then the patient is liable to pay for something that the clinician has prescribed and that is accepted in guidelines.

The ICD10 codes for claiming for HIV treatment also don't cover treatment for HIV related or even separate conditions that people have, so many patients have HIV but they also have depression or they have HIV but they also have diabetes and that requires patients to see 2 GP's to get the 2

different scripts, so many of the medical schemes ask the consumer to choose an HIV provider and a GP and you see your HIV provider only for your HIV related care and your GP for all other care and what that means is that the HIV provider is not able to write the script for diabetes, so the patient must go to see multiple clinicians instead of being able to go and see one person.

The Council for Medical Schemes is auditing the HIV management companies and the issue of script expiry has been taken very seriously. Doctors are regularly faced with the scenario in which a patient calls in at the last minute to say that their medication is finished and they are unable to get an appointment with the doctor for a follow-up for various reasons for a couple of weeks and sometimes there is a difficulty in contacting the doctors rooms, or getting a repeat script issued.

So in order to avoid treatment interruptions, this has typically been dealt with by contacting the doctors and getting consent to issue a 1 month repeat script if the patient has been adherent for the last few years with an undetectable viral load. The doctor will then be notified and requested by email or fax to urgently provide a new script and new blood tests, but what happens is that the auditors with the Council of Medical Schemes have warned that this is a

contravention of the rules and that scripts cannot be issued and accepted accept for the original from the treating doctor.

The challenge with this is that it now results in many patients who have been adherent for a number of months or a number of years experiencing interruption in their treatment and this could result in the development of resistance at some stage especially with the NNRTI based regiments, it could seriously affect long term outcomes if the doctors are concerned about those script rules being applied to rigidly.

The second issue is around potential conflicts of interest and this relates to Regulation 15 of the Medical Schemes, I am not a lawyer, but I will read out the Act and then I will read out what our doctor members are concerned about, so it is 15(h) and 15(i) about protocols and formularies. If managed healthcare entails the use of a protocol, provision must be made appropriate exceptions where protocol has been ineffective or causes or would cause harm to a beneficiary without penalty to that beneficiary and formularies, if managed healthcare entails the use of the formulary or restricted use of drugs, provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause an adverse

reaction in a beneficiary without penalty to that beneficiary.

So referring to these regulations, some of our doctor members in the private sector have experienced an issue with medical schemes, where even though a medical advisor is appointed by the scheme, a decision made by the appointed advisor is overruled by the scheme, usually by someone like the senior pharmacist, as the ruling does not fall within the scheme's guidelines.

The scheme regards the guidelines not as a guide, but as a protocol which cannot be altered in any way, making the appointment of an experienced medical advisor almost pointless in serving the dual needs of the best clinical advice for the patient, coupled with the best cost process for the scheme.

The trustees of the schemes often question medical decisions which may be in the long term interest of the patient, but do not fit in with the short term annual financial budgets. The bottom line is that the schemes do not understand that private doctors recognize the need for cost efficacy and cost savings but need to combine these issues with patient health and wellbeing which involves a consideration of the effects of the drugs on a patient.

The third issue is the relationships between medical schemes and courier

companies. The society has received complaints about the inefficiencies of courier companies, for example medication being sent to patients is changed without informing the patients and without communicating to them, reasons why there is a change and how the new medication is used and possible side effects, as would usually be done when a patient gets medication over the counter in a pharmacy.

Section 6 of the National Health Act specifically states that the healthcare users have a right to full knowledge of the treatment options available and the associated risks and benefits and the process of changing a person's treatment without consultation, is a breach of that right.

Regulation 15 of the Medical Schemes Act, limits the prescription of formulary drugs if they adversely affect the patient. However, the dialogue between the patient and the healthcare provider is suppressed by the courier process and patients have no way of safeguarding against unrepresentative changes in their medical regimen. This may be a breach of the regulations of the Medical Schemes Act, but is indicative of the need for openness and transparency between medical schemes and members.

The closed relationship between medical schemes and courier companies creates information asymmetries which may reduce the patients' ability to participate in the determination of their own healthcare needs.

The forth issue is TB treatment in private health facilities. TB is currently being treated in the public sector, which is a huge challenge for patients using private health services as they are often required to go to public institutions for treatment which they would rather not do due to the time involved and work commitments etcetera.

It is also unclear if medical schemes actually pay the public institutions the minimum amount that they charge and are due for the patient to pay. This places an additional burden on State facilities. In addition, because of the lack of clinical training, many private GP's do not know how to treat TB and do not recognize it when seeing it in their practices and even though South Africa has one of the highest TB rates in the world, PMB coverage for TB in the private sector at this stage, is limited to diagnostic tests. The responsibility of treatment of TB is left to the public health sector.

Patients with private health insurance are forced to use over-burdened public health institutions. The private sector is well resourced and should train

private healthcare professionals on TB diagnosis, care and treatment as it is required to provide this treatment in terms of our understanding of the PMB regulations.

The fifth issue is medicine shortages and stock outs. Shortages of HIV and TB medication as a result of stock out, has been an enormous challenge as it impacts…

JUSTICE NGCOBO Can I ask you a question on the point that you have just made and that is the treatment of individuals with TB at public institutions. What is the concern there?

MS JANKELOWITZ The concern is that it only happens at public institutions. It doesn't happen in the private sector.

JUSTICE NGCOBO And why is that so?

MS JANKELOWITZ We think it is because there is a misunderstanding within the sector regarding where TB can be treated and because TB is a notifiable disease, so what happens is that diagnosis may happen in the private sector and there is some coverage for diagnostic tests but then the patient is referred for the treatments to the public sector.

JUSTICE NGCOBO Even though the patient is willing to pay the private sector charges?

MS JANKELOWITZ Yes even though the patient is willing to pay.

JUSTICE NGCOBO And is able to pay?

MS JANKELOWITZ Yes, is willing to pay, is able to pay. The clinician is not always able to treat just because they have no experience in it, but that is relatively easily fixed.

JUSTICE NGCOBO Because they have no experience in the private sector?

MS JANKELOWITZ Yes.

JUSTICE NGCOBO How is that so?

MS JANKELOWITZ I think it is like I say, a misunderstanding of where TB gets treated, so if TB gets treated in the public sector, private sector clinicians pass on that responsibility if they see TB in the first place, so a lot of the time TB gets misdiagnosed. It doesn't get identified in the private sector, because the private sector clinicians have so little experience working with TB. When

it does get diagnosed, it then gets referred to the public sector.

JUSTICE NGCOBO So if one follows this logic and whenever you have a TB patient going to the private sector, the patient gets referred to the public sector. Then it means the private sector will never get experience, so the system tends to perpetuate itself?

MS JANKELOWITZ Yes and the experience is possible, it is not an impossible task to fix that. It is relatively easy to develop guidelines and to train clinicians in how to apply them.

JUSTICE NGCOBO Thank you, you may proceed.

DR BHENGU How does what happen in the mining industry affect your statement?

MS JANKELOWITZ So what happens in the mining industry, is that the mines themselves often take responsibility for TB. The difficulty is that that while the patient is employed. If the patient is no longer employed or moves off, the patient might still be on medical aid, but moves into the public sector and it doesn't always apply to family members, so the family members are

being treated in the public sector and the miner for example is being treated by the company.

The fifth issue is stock outs. Shortages of HIV and TB medication as a result of stock outs are a big challenge, I have mentioned that. It impacts on treatments patients may develop resistance down the line if they don't take their medication as required. It also impacts on the messaging, we spend a lot of time messaging to patients about adherence and if medicines aren't available, it undermines that messaging.

Patients from the public sector maybe referred privately to get their medication during a public sector stock out and what that does, it causes a number of difficulties for patients because they now need to pay for medication when they are not private and they don't have medical aids, but it also creates a shortage within the private sector for the private sector patients that are expecting their medications there.

So there are number of difficulties experienced by members without medical aid accessing private healthcare, these patients often do not have the resources to pay out of pocket for medication. The Government is required to provide affordable healthcare in its efforts to realize the right to healthcare

and the private patients are entitled to get their required medication when they attend the clinic.

There are a few smaller issues that are not part of the written document that clinicians also complain about. I will just briefly mention because they came up earlier and the one is non-evidence based medications and that patients are often being drawn to alternative medications that conflict with the medications that have been prescribed by the clinicians and this is difficult and I know that there is legislation happening or pending in terms of alterative medications, but this is a constant issue for our clinicians and the other issue that we get told, we get told that the cost of medications antiretroviral specifically, have been pushed down for the public sector. The only way that the companies can then make back some of that loss, is by increasing the costs in the private sector. I am not sure how true that is or how relevant it is, but it is something that the private practitioners complain about, thank you.

JUSTICE NGCOBO Thank you.

MR EAGAR I would just like to thank the Commission specifically for the opportunity to address you today. My name is Daygan Eagar, I work

for an NGO called the Rural Health Advocacy Project. We are an NGO that focuses on the right to health and the right to have access to good quality healthcare for rural populations.

We were established as an NGO by the Rural Doctors Association of Southern Africa which is an organization which represents rural doctors, not as a trade union, but as a body that supports doctors in advancing the right to have access to care in rural areas, so it is more of a doctors movement towards good quality care in rural settings, as well as Section 27 which is one of our key partners.

Initially our focus as an NGO, was to focus on supporting doctors in specific issues that they bring to us, that they can't take up within the health system themselves for whatever reasons, whether it be victimization or lack of capacity. Over the last 3 years however we have started working in areas of policy and budgeting with a view to ensuring that all policy and all health budgeting and financing takes cognizance of the rural context, takes cognizance of the healthcare context in which people are accessing service in rural areas, something which has been wholly neglected over the last twenty years. One can argue over the last three hundred years, which is probably

more appropriate.

Our focus on rural health in particular is one that I think is quite important and one that we feel has been neglected, is largely due to the fact that about 39% of our population still resides permanently in rural areas. That number expands at various points in the year where miners from Marikana for example will travel back to the Eastern Cape to be with families over the Christmas break or once they retire, or are forced to leave employment, they often go back to homesteads in rural settings in the Eastern Cape and KZN, so as a component of our country as a population rural settings are central.

Rural context in South Africa, also has the unfortunate position of being amongst the most, if not the most deprived districts in the country. If you look at the multiple depravation indices, places like Lusikisi and Port St. Johns are always leading in relative deprivation unfortunately. They also have comparatively high levels of the burden of disease both HIV, TB, non-communicable diseases such as diabetes, high blood pressure all extremely high within rural settings, so basically the need for care is extremely great and one could argue is perhaps greatest in whatever sector you look at.

The trouble with rural South Africa is that there is a historical legacy of neglect. There is very little in the way of adequate infrastructure to support healthcare while a lot has been done and a lot of commendable work has been done to improve access to healthcare through the development of primary healthcare facilities, access still remains extremely low within rural settings.

This is driven by a shortage of healthcare workers particularly a shortage of specialists and doctors in many settings. The equitable financing of rural health settings and we have research that we can share with you that demonstrates how budgeting from the apartheid era has actually carried through to this day and that is due to a process of incremental budgeting and no assessment of need within the way the public sector finances healthcare. That is starting to change and people are starting to look and work on that, but the system itself is very reminiscent of what we would have found in 1990.

Our basic argument and one of the primary reasons we focus on rural areas, is the rural health context provides what is possibly the clearest example of structural violence when it comes to healthcare, where structures and the provision of services or the lack of provision of services in the way health

system more broadly and this is where the private sector comes in, is set up in such a way that it is actually violent towards the population and you can see that in mortality rates, morbidity rates, quality of life. If you have ever met someone with a disability from a rural setting, you will know that there access to treatment is virtually zero and their quality of life is extremely low.

Our point of departure is that if we are going to advance the right to health in South Africa, rural areas need special attention. This does not necessarily mean attention to the detriment of other sectors of the population, but they need to be considered as a group that has been historically and structurally neglected.

So what is our interest in this particular Commission? Initially I was quite skeptical that we had any role to play in providing input here and one of the reasons for that is that private sector provision provisioning of services is extremely limited within rural settings. There is limited access or availability of general practitioners in rural settings. There is virtually no private hospital provision or specialist provision in rural settings beyond some of the larger towns or cities in rural provinces such as in Umtata, or Port St Johns has

some limited private care provisioning.

That private sector access within rural areas is limited to Government employees who have medical aid. If you look at the numbers and we don't have the numbers that separate rural areas from urban areas, but if you look at it by province, a province such as the Eastern Cape has a third of the number of people on medical aid that Gauteng and the Western Cape do and that is concentrated in the large cities.

Access to private healthcare is ten-fold higher in urban centres than it is in rural centres, so there is essentially no private healthcare for the majority of rural people. That being said, what we are seeing, is an opportunity with the introduction of the National Health Insurance as a system-wide reform in the way health is going to be delivered in the country as an opportunity to start looking at what sort of impact would incorporate in the private sector into a reformed process such as the NHI have on rural populations and their access to services.

One of the debatable positive points of the NHI is that it is going to open up access to public sector patient, patients without medical aid who will then be able to use private sector care and providers. One of the issues here and this

is one of our concerns, is if for example you open up access to private hospitals, without appropriate regulation of where healthcare is located in the private sector, we are going to start seeing an increased supply of healthcare in urban settings, increased access with resources flowing into urban centres, continuing to flow even to public sector patients to the detriment of rural patients, rural communities.

The burden will then fall on Government once again to broaden access to care and one of the issues here is that we fail to deal with the issue of the certificate of need for example. The very basis for how we determine where healthcare will be established, how we ration healthcare and how we offer healthcare based on principles of geographic equity and this isn't only a problem within the private sector. It is one that we find within public sector itself.

So our main input is that we need to urgently and perhaps this is beyond the prevue of the Commission, but we would like to see it as one of the recommendations, is that we really look at the certificate of need. The last process with its promulgation was deeply problematic and we actually provided a submission to the National Department of Health cautioning them

against the approach that they took to the promulgation of the certificate of need, but this doesn't mean that the process should be done away with in its entirety.

We appreciate the arguments that the Constitution provides for freedom of association and various other private property rights and I am not a lawyer or an advocate, but we would argue that certain rights within the Bill of Rights should be limited in the interests of not only access to healthcare, but the life and death matter that Mark was talking about, but also a broader transformative agenda in the country. I think this is something that has been missing from our debates around regulation of the private sector. It has even received limited debate in the NHI debate around the NHI and transformation and reform of health in South Africa, is about transformation, it is about re-distribution.

The NHI has the potential to be one of the first meaningful re-distributive processes in the country and we will argue that those fundamental principles that underpin our democracy and constitution provide some limitations on the right to association for example. Not in its entirety, the constitution does call for reasonableness in these limitations in Section 36 of the constitution. It is

not a case of getting rid of the private sector, absorbing all those resources into the public sector, but it does call for greater regulation and management of health in a way that more appropriately addresses what our country is underpinned by.

Healthcare as a market doesn't function like any other. If anything, what is happening globally and the movement towards socialized medicine which has become a bit of a derogatory word in the US, shows that this sort of thinking and movement is happening with great regulation of healthcare.

People recognize it even in the most liberal economies, societies, these debates on how to regulate the private sector provision, is ongoing and we really feel that the debate needs to extend beyond purely mechanistic debates around cost whether the private sector is over pricing, but the fundamental role of the private sector in a constitutional democracy thank you.

JUSTICE NGCOBO In your written oral submission, you make the following statement, we end our submission by presenting a scenario where if private sector service provision is not meaningfully regulated particularly in private hospitals and by specialists, opening this care to public sector patient

under the NHI, could actually deepen geographical inequities in access to services. What do you mean by that?

MR EAGAR Our contention there is that if for example we don't address the certificate of need, so we don't address how we regulate where private hospitals are established, currently the only basis for regulation of where private hospitals are being established are provincial regulations around licensing and those generally only address issues of quality. They say nothing about whether we have too many private hospitals in a particular geographic space, whether we have too much over-provisioning and I am sure you would have had submissions talking about over-provisioning within the private health sector.

If we don't address those things now and we enter into the NHI and we start accessing services or the public sector starts accessing services in the private sector, what you will see happening is people living and residing in urban areas, will have greater access to services. Those will be improved and that is a moral ethical good, but that doesn't provide the basis for drawing those resources to where historically they are needed the most. One of the arguments for including the private sector in the NHI and reform processes is

because of their skills expertise and resources contained within that sector.

There is no incentive for a private hospital group to open in a rural setting, by virtue of the fact that low population densities and high burden of disease. It is really an expensive practice to provide services in a private setting, even in a public setting.

JUSTICE NGCOBO I understand what you are saying, but I think my real question is given the picture that you have painted in relation to healthcare services in the rural areas, how does one address the issue of access in concrete terms. What are the sort of steps that must be taken to ensure the access that you are talking about?

MR EAGAR There is a large burden on the public sector to improve that access and it extends just beyond the healthcare sector. Arguably one of the most significant barriers to access in rural settings is distance and poor road infrastructure and a lack of transport in accessing services.

What is needed there, is a concerted effort in understanding what sort of resources are needed and how those services are best provided within those settings. One of the concrete measures that we argue for and this may down

the road, have implications for the private sector, is to come to a definition of what is rural and what is urban. At the moment, the Government is operating from a common sense definition of what is rural. Rural is what we think it is, what we imagine it to be without any structure and understanding. I think understanding that in the first instance and then we can start developing mechanisms such as funding formula that adjust for those rural context, the cost of providing and developing services in rural settings.

JUSTICE NGCOBO To your knowledge, has there been any detailed study, research study which looks into the issue of enhancing access to healthcare services in the rural areas that we can have regard to that we can look at?

MR EAGAR Absolutely we have undertaken over the last 3 years extensive research into this very issue. In fact we recently published a discussion paper in the South African Health Review on approaches to defining rural that allow for it to be integrated into technical processes, whether it is healthcare planning or budgeting at the Treasury level. We have also done reviews of international evidence of what works and what doesn't work in regard to improving access to rural areas. We have done the same on more specific issues around access in South Africa and what needs to take

place to improve those, so we would be happy to share that literature and research with you.

JUSTICE NGCOBO I think will be helpful if you could make that documentation available to the technical team, so that they can be published on the website so that everyone can have access to them thank you.

MS MUVANGUA Sorry Chair I just have a quick question for you. When you talk about promoting private healthcare access in rural areas, I accept your argument about the NHI, but why do you speak more broadly on affordability because public health care comes with means, being able to afford. It was spoken earlier by your partners that the greater percentage of the rural communities are impoverished. How do you reconcile the two?

MR EAGAR Can you just repeat the question? I don't think I got the gist properly?

MS MUVANGUA Section 27 made a presentation in part earlier which intimated that the greater majority of the rural population is impoverished and you seemed to have touched on that. Your presentation seems to suggest that private healthcare should be provided in rural areas. How do you reconcile

affordability in the 2 scenarios?

MR EAGAR Okay I am going to go out on a limb here. My personal view is that within healthcare, private sector should have a very limited role. There is some argument for market competition in containing prices. Evidence from abroad is that even with regulation it is extremely difficult. If it was up to me, we would have socialized healthcare and there would be no private sector provisioning, but as a pragmatist, understanding that we have an established private sector with skills and resources, we need to start looking at mechanisms that allow private sector provisioning under different terms to what we currently understand the private sector to be in South Africa to operate within the public sector in rural areas.

One example where the Government is trying to do this, is contracting of private GP's to provide services within the public sector and a lot of work has gone into doing the modelling around how the cost of that private sector provisioning is not necessarily higher than it would be in the public sector. Some work has been done about provisioning of medicines at private pharmacies where they do exist within rural areas and with the cost and comparative trade-offs make it an affordable option, in many of those pilots

where that has been done in the Western Cape, it has been shown that the profit motive has meant that those services are extremely limited and a difficult process to implement.

The fundamental basis of healthcare provision in South Africa is the right to have access to healthcare and that in our view, over trumps the other rights in the Bill of Rights to some extent and obviously that needs to be reasonable and that still needs to determined. That needs to be tested. One of the failings is that we haven't tested these rights and property rights and right of association constitutionally yet. The land question, people are saying that the constitution is a barrier to land transformation and land reform, but that has never been tested and I think within healthcare, the same applies.

What we would have liked to have seen with the certificate of need issue, as poorly as it was implemented or tried to be implemented I think it was last year or the year before, is to go to the Constitutional Court and for it to be tested there under rigorous arguments. What does the Constitution say about this? For us, that is really where we are situated. We need to go down that road.

MS MUVANGUA On the certificate of need, do you foresee any competition dangers. What comes to my mind such as market allocation, could a certificate of need lead to a situation such as market allocation in your view?

MR EAGAR I am not an Attorney and my knowledge of health economics is quite limited and I would leave that for the other experts in the room to mal over, perhaps it is something that Section 27 could look into.

MR SELEKA On the certificate of need, just a question of clarity, is my understanding correct that you are saying is being applied on the basis of quality of care instead of quantity of healthcare available?

MR EAGAR Currently the certificate of need provision within the National Health Act, isn't in force. It was promulgated and then repealed. The way services are determined within the private sector in my understanding is based on provincial regulation of licensing of private sector facilities where they are established and that only focuses on quality and it says nothing about geographic equity or determination of need whether the facility is needed.

So currently the certificate of need is in a grey area and it has been like that since the National Health Act was first brought into force and it remained so and that is a battle that is ongoing.

MR SELEKA So there is a Section 36 in the National Health Act so that section hangs in the balance? Is that right? That deals specifically with certificate of need?

MR EAGAR My understanding is that section stood outside of the National Health Act because it wasn't promulgated. It wasn't brought into force until there was an attempt I think it was last year in 2014 to do so on advice from various sectors and the Department of Health then repealed that enforcement of the certificate of need. As it stands in the National Health Act, it has no force, it has no power.

JUSTICE NGCOBO I think in fairness to you, Section 39 of the Act this is the National Health Act, empowers the Minister to make regulations after consultation with the National Health Council dealing with the requirements for the certificates of needs. So do you know whether those regulations have been made? In particular, Section 39 (2) (f) makes it clear that those regulations must seek to avoid or prohibit practices or perverse incentives

which adversely affect the cost or quality of health services or the access of users to health services. Those are the issues that the regulations which are required by the statute must address. So I don't know whether hopefully we will hear in due course whether or not those regulations have been made and the extent perhaps to which they address your concerns thank you.

MS CHAMBERS Good afternoon, my name is Cassey Chambers and I am Operations Director at the South African Depression and Anxiety Group. Thank you to the Chair and to the panel to give us this opportunity to highlight mental health on such a platform and to give patients a voice. It is meaningful and it is a great opportunity for us to be included, so thank you very much.

So to touch base on who the group is, we have been running for the last twenty two years being one of the leading mental health advocacy groups in the country. We work very closely on de-stigmatizing mental illness and psycho education. The core of what we do, we run a call centre that offers free telephonic counselling, information and referrals and that is also why we were brought here today, because a lot of the issues that we get on a daily basis from patients, family members is what we are going to present on some

of the issues that we have highlighted.

On an average day, we receive over four hundred calls per day into the call centre. We operate every single day of the year and through the work that we do, we work both in rural and urban settings. Some of the background into SADAG's involvement in the private healthcare system and even medical schemes, we work with very closely with the South African Society of Psychiatrists SASOP on advocating for the bipolar algorithm to become a PMB chronic condition.

We also host various patient awareness workshops to help patients as well as family members and caregivers understand medical schemes, the processes and their benefits. We have also worked quite closely with Discovery Health on their mental health benefit in putting together a psychology review panel as well as treatment guidelines for anxiety disorders.

As mentioned earlier from Section 27, we were quite actively involved last year in 2 different advocacy cases. Some of the key items that we would like to highlight today and again this is all derived directly from patients that are calling us with issues and concerns. Again I have no legal background

whatsoever, but just to give the patients a voice and to give them this platform.

The first thing I would like to highlight is the inadequate prescribed minimum benefits cover for mental illness. We all know what the medical schemes act includes, how a patient has to meet certain requirements in order to receive those benefits from the PMB conditions, but from that, we also know that bipolar mood disorder and schizophrenia are the only ones listed as a chronic condition. Major depressive disorder is covered under the two hundred and seventy DTP's.

Depression is only covered for hospitalization the twenty one days or fifteen consultations depending on the health plan that that patient is on. Several forms need to be submitted as the benefit is not automatically available, so the patients are not aware about the processes, what forms, what motivations and often hit a lot of problems with getting doctors to comply with that and filling in the forms and accessing the treatment.

We need according to the WHO, that depression is a common mental disorder and it affects over three hundred and fifty million people around the world. Depression we also know is the leading cause of suicide worldwide and when

we look at the stats specifically for South Africa that says there are twenty three completed suicides in the country every single day and a further four hundred and sixty attempted suicides every twenty four hours. Depression being the leading contributing factor to suicide, we know that this affects a lot more people than what we believe.

The second issue that we would like to highlight is the limited medical treatment for non PMB conditions, so medical schemes are required to provide cover for treatments, procedures, investigations and consultations, listed for each specific condition on the DTP list. Members are however not aware that they have to submit again additional motivation documents to motivate for treatment that is needed. The medical scheme can review such information and may choose to approve the treatment, or in some cases, reject, but then the info with regards to the appeals process is not necessarily educated or translated for the member.

The process is not readily available or explained to the patients and often, these patients with a mental illness are already vulnerable and compromised so in that state, you now have to take more time and more energy, they often give up before even pursuing it. Some medical aids offer comprehensive

benefit options through the chronic medicines packages. They cover more than just the twenty seven PMB conditions, but that is only available to patients on top end medical plans and are able to access medication from their chronic medicine benefit for illness that are non-PMB conditions such as generalized anxiety disorder, MDD, OCD and PTSD.

When we look at the context of mental illness in the country and the high rate of co-morbidity, you are going to be having a patient who has more than one diagnosis, needs a complex array of medications, so currently what we have on our PMB conditions, does not cover for those complex issues. The third thing we would like to highlight is the range of medications that are restricted to those listed only on the formularies, so we know that the Council of Medical Schemes regularly updates the therapeutic algorithms or protocols for treatments of PMB's.

This then acts as a guideline which medical schemes are then able to use to compile the formularies or medicines list of drugs to treat chronic conditions. Often patients experience stock-out situations and we experience this both in the public and private sector. These patients then are forced to either change their medications or because of due to stock, receive no meds at all and then

they are further compromised which affects their treatment plan.

This doesn't give patients a chance to stabilize on the treatment that was prescribed and puts them at a high risk of relapse. We know that relapse is a lot more costly and a lot more difficult to manage if you are dealing with a patient who is non-compliant. Psychiatric medications often have serious side effects and take at least 4 to 6 weeks before they start working, so a patient who is going through all these different stages, may look at stopping their medication or falling off the system.

Consequences of changing meds are higher than any other conditions. There are so many different reasons that patients with a mental illness stop taking their medication whether it be compliance whether it be side effects whether it just be access and cost. We also have generic substitution. We know that the mandatory substitution came into effect in 2003 where pharmacies now have to notify private patients about availability and benefits of generic alternatives.

The pharmacist must dispense the generic unless the generic is more expensive than the branded option as scripted, or when the presciber has explicitly stated that the branded drug must not be substituted. Another issue

that we often experience is that the prescribing doctor is informed that the patient is being switched and unfortunately they don't mention on the script that the patient needs to stay on that branded option if that there being their first line treatment.

When the brand is on the MCC list of non-substitutable medications, it offers some other issues that for a patient again to now have to try to navigate through this can be incredibly difficult. Some of our challenges because of that include patients complaining that when they have to switch to a generic, after being well controlled on a branded option, they don't have the same treatment benefits, they may experience more side effects and again, increased risk of relapse.

Due to this, they experience negative side effects, their symptoms last longer they are harder to control. Also their negative outlook as to getting treatment for mental illness, we definitely find that more patients drop off getting treatment, therefore don't take treatment and a few months later and we see this on our suicide line, is often one of the first few questions we ask and we find out if the patient has recently stopped taking their medication and then they need acute care and they need emergency crisis which again, costs more

and long term it is very difficult to manage and control that patient.

Often bad experiences or negative side effects are mentioned as reasons patients stop taking medication for their mental health issue and therefore reducing compliance. Co-payments made by patients on private medical schemes most medical schemes use reference pricing as cost effective prescription prescribing, most common ones used are generic references on the maximum medical aid price or the medicine price list. The patient can only choose a generic from the defined list and again, each medical scheme has their own list of formularies that are available. There is no standard formulary list.

If the patient chooses a product exceeding the price of the benchmark generic, there is an out of pocket payment that they are then responsible for. The problem is that the price model varies in terms of benchmarking methods. There is no standard such as the lowest average or selected generic.

Many medical schemes have an exclusion list of medications that are not cost effective according to that scheme, so that just reduces access for that patient to get treatment where the doctor may have prescribed it, but because it is not on that list, it is not an option for that patient.

This approach is not patient centered, but rather more focusing on cost effectiveness or what is cheaper, again leaving the patient to have to manage this when they are already in a vulnerable state. If a patient chooses a mental health professional not part of the DSP, they would have to pay out of pocket. Again they are not having the opportunity to work with professionals or specialists who specialize in their specific mental illness but only those that are on that DSP list.

If a patient is prescribed a non-formulary drug and chooses to use that specific medication as per the instructions of the doctor, they risk again the out of pocket payment when the drug exceeds the maximum payment amount according to the price threshold. The medical aid option plan determines what co-payment that patient needs to make, for example the high end option patients provide more benefits therefore there is less co-payment for them, so the lower your plan, the more co-payment that you have.

Again, often patients then make the decision not to pursue further treatment and then they stop taking medication, reduce compliance and we see that cycle occurring again. The challenge that we have with this, is the cost of drugs to treat mental illnesses are very expensive, resulting in some patients

stopping medication and not taking their medication due to high cost and not being able to afford medication out of pocket for their treatment period.

Often not being able to afford the generic option, even if that is available as well, this impacts severely on the management of their illness. Again as mentioned, we have that never ending cycle of a patient not being well. Our sixth item that we would like to highlight is the limited hospitalization benefit. We know that according to the diagnostic treatment pairs or DTP's, determines how two hundred and seventy PMB conditions should be treated. This should be based on healthcare and affordability in the best interest of the patient. If there is a disagreement between the medical schemes and the treating professional, then they apply the public sector standard which is of best practice and protocols.

However, with the hospitalization on PMB for mental illness, it is capped at twenty one days or 3 weeks. Already we are having patients call the call centre who have already reached their cap for the year with medical schemes kicking in at the beginning of the year, they have already used up their twenty one days and that means that for the rest of the year, they have to be really careful in not accessing treatment and if they do have any emergency, they

have to go to State.

This is simply just not enough for patients to be stabilized and ready to go home after 3 weeks especially when dealing with complex or dual diagnosis disorders. There is often no long term treatment or maintenance plan after the hospitalization. It is not an and or situation. They only get twenty one days. If they use some of that, then they get some treatments with the therapist, but often the patient is in for the twenty one days full.

For example, a case study that we experienced last year was a 16 year old boy who had attempted suicide twice in one week. He was hospitalized for 3 days for the first attempt and this was under his PMB hospital based management which is up to 3 days. He was then discharged where he then attempted suicide twenty four hours later. He went back to the same hospital who turned him away due to no more benefits. The teen was then sent to the State hospital and placed in the adult ward, because in our State facilities we don't have enough facilities for adolescents.

During that time of being in the State hospital, he was assaulted by fellow adult patients. It was then recommended by the doctor that it would be safer to go home without professional treatment rather than stay in the State

hospital. Again this is not giving adolescents or a patient a chance to stay and get well. After running out of the PMB benefits for the year and that seems to be one of our most common complaints that we are getting from callers and from emails around the country, is that patients are then forced to go to State facilities for treatment or pay out of pocket if they can afford treatment.

A family where we know that mental illness is hereditary the mom might have depression so her children might be at a higher risk for depression she now has to choose to manage the family's health care. It is her priority to rather make sure that her child has access to a doctor for medication or that they have options for a therapist at her own expense where she doesn't then claim from her medical aid to ensure that there is enough benefit for the whole family.

After running out of the PMB benefits for the year, when they go to a State facility, they have to be re-assessed by the psychiatrist, so starting from scratch, opening a file, taking a day off to go sit at the State facility, they have to change their meds due to what is available on the State formulary or the State clinics, not necessarily what they have been maybe been on for a

couple of months or what they have had access to.

They often experience stock-out problems and have to go back. I often have patients who are told we don't have your medication for bipolar disorder this month, but please come back next month. By then the patient has relapsed and they have been readmitted into hospital and then they have built up a resistance to that medication and we start from scratch, therefore negatively impacting their treatment, wellness and functionality. A patient who is not getting access is not getting treatment is also then going to be taking more time off work, is going to be having more problems at home, maybe self-medicating and the cost to the overall economy and again I am not an economist, is a lot more than offering them treatment.

According to one of our callers and again this is giving the patients a voice, is medical schemes are completely non-negotiable on this time limit which is entirely discriminatory, as cap limits do not apply to most other health conditions. Furthermore, each case should be assessed individually and a blanket generic approach should not be applied. Again it just shows how each case is so complex and yet we don't account for that.

Specialist treatment is very expensive. I know at the moment for a psychiatrist and normally you have to pay upfront, it could be R2500 that a patient has to pay upfront for the first session and then claim from the medical aid. We also know that specialists charge 200% to 300% above medical aid rates and who is responsible then for that co-payment?

Often these patients have to make out of pocket payments or reduce the number of visits that they can make to the specialist due to what benefit is available to them and that includes your psychiatrist, neuro-psychiatrist or clinical psychologist. Patients often have to visit the specialist face to face to fill in the chronic application form which costs them money or is the cost of a session, therefore reducing their treatment plan.

Many specialists charge the patient upfront and it is the responsibility of the patient then to claim back but again, we are dealing with a mentally ill patient who already is feeling very vulnerable and now has to navigate the system of filling in forms, getting documents assessed and often they give up. Doctors are also very reluctant to fill in the form, because they don't want the extra admin or paperwork and the person that suffers again is the patient.

Many specialists refuse to fill in the chronic application forms and also some don't know how to fill them in. They haven't been educated on what the process is. Often specialists aren't able to even inform the patients on what process they should follow, so often they will provide a script or treatment but not then to explain to the patient on how to follow-up with their medical scheme.

Mental illness and that is why our involvement in today is such a great opportunity, is that mental illness isn't considered serious like other conditions. Just this morning we received an SMS from a patient who is saying that it is difficult to let people take her seriously because she can't get a blood test for her mental illness, she can't get the lab to explain that she has a mental illness, so to have to convince that this is real and that she needs treatment, is incredibly difficult.

We have the twenty seven chronic disease list and the two hundred and seventy designated treatment pairs which already show that mental illness is marginalized in the terms of what treatment is available, the hospitalization cover and the specialist consultations. Mental illness overall is not taken as seriously in South Africa as other chronic illnesses despite the fact that 1 in 3

South Africans will or do suffer from a mental illness in their lifetime, so it affects a lot more people than what we are made to believe.

SA has a great mental health policy on paper, but we know that it is not being implemented across the board. It is lacking important information with regards to financing, prevalence, demographic analysis. Also with the high incidences of depression amongst patients suffering from chronic illness and again knowing that depression will be the leading burden of disease by 2030, is a huge concern because we are not taking this into consideration when patients are getting treatment for diabetes or hypertension or cancer.

Info is not readily available to patients about treatment and options, medications or DSP's. We know and this is something that a lot of people and even doctors aren't aware of is according to regulations of the Medical Schemes Act, the medical scheme is obliged to provide an appropriate substitution drug to a patient without any financial penalty to the beneficiary when formulary drugs have been ineffective.

It is never explained to patients, it is never made available, they don't understand the process and neither do the doctors know this either. Many doctors don't even know how to start navigating this.

If a patient's treatment is ineffective on a formulary drug which is fully funded and the patient can supply all the necessary documentation and motivating information, the scheme is obliged to find an alternative and proven drug in full. However most medical schemes require patients to follow an appeals process which is difficult and time consuming, again patients don't follow through at the expense of themselves.

Often new medical scheme members are subject to a waiting period. They have to wait a minimum of 6 months or more before their cover comes into effect, especially if they haven't been on a medical scheme for the last 2 or 3 years. Members don't read the list of exclusions until they need the benefit. It is a lot of paperwork, it is a lot of documents, a lot of words that patients don't understand.

The waiting periods and exclusions are not explained to new members and again this brings in the question of brokers and their role in playing this and educating them to educate their members. Members are expected to read and understand this and they normally get this information only after they have joined the medical scheme.

Some of the recommendations which in our oral submission in our written report is a lot more extensive, but just to touch on a few, because I know I am running out of time, is mental illness needs to be taken seriously as any real medical illness that needs real treatment. PMB conditions needs to be urgently reviewed and updated to adequately provide the treatment that complex mental illness needs. Brokers and medical schemes need to be upfront and educate their members about benefits processes, cover limitations.

According to international guidelines and best practice, mental health is listed as an essential health benefit that includes both inpatient hospital based care as well as psychotherapy and counselling and that is incredibly important due to the maintenance. If a patient has been hospitalized they then have maintenance such as psychology and support services, it prevents them from relapsing and then costing the medical scheme more money. Again I am not an economist, but I know there is a lot of research and I am happy to provide that that for every $1 spent, it has a yield of 15 X more and I think it is really important to take that into consideration too.

Coverage should start the day that a member joins a medical scheme so that

they are not by the time that their cover does kick in then they really need acute treatment. Where we need proper regulation of tariffs charged by specialists, medical schemes and hospitals, but not to be at the cost or the penalty of the patient. We can't expect medical schemes to cover the load and to take on this huge expense. It should be regulated across the board.

We need to adopt patient centered approach to mental health benefits and treatment guidelines. This again just yields better success rates, prevents relapse as well as drug treatment resistance. Access to mental health care is not a commodity, but it is a human right and it should be treated as such.

Medical schemes should built better working relationships with mental health NGO's to provide additional support and services to patients with mental illness, including access to support groups, information resources. Again we shouldn't work in silos we should all be working together in the best interest of the patient. We need to provide access to information regarding medical scheme benefits and processes both that are user friendly and easy to understand and not hidden somewhere on someone's website or in the fine print of a long document.

We need to train the call centre staff at medical schemes on how to better inform their members on the various processes, benefits and treatment options. I often have patients who are incredibly frustrated because the call centre staff, don't even know how to navigate or how to explain it to them and they often have to figure it out themselves. Thank you very much for your time.

JUSTICE NGCOBO Thank you for your presentation, can we move onto the next presenter?

MR EAGAR Sorry Chair before we get started, I must excuse myself, I need to get to a board meeting, so I do apologize.

JUSTICE NGCOBO Yes thank you.

MS CHAMBERS Sorry Chair before you start, I also need to excuse myself.

JUSTICE NGCOBO Thank you.

MS SUNKEL Good day thank you very much for giving us the opportunity and giving mental health a platform here to contribute to this inquiry. My name is Charlene Sunkel I am a Programme Manager for

advocacy and development at the SA Federation for mental health. I am also a mental healthcare user myself, having been diagnosed with schizophrenia myself in 1991.

Just a bit of a brief of my access to mental healthcare, I do at the moment, still access public healthcare services where I go to the community clinic. Unfortunately every 6 months I go there for treatment and the normal thing is you basically wait there most of the day. Fortunately my employers do understand the situation. Every 6 months I also see a new psychiatrist as they rotate, so there is no possibility for service users to build a relationship with a psychiatrist and especially when you have a mental illness it is difficult to trust new people, so you never get to trust your treating psychiatrist.

I am going to talk a bit more about the organization. SA Federation for mental health is non-profit non-Governmental organization. It is made up out of seventeen mental health societies across South Africa and also more than a hundred member organizations all actively involved in the field of intellectual and psychosocial disabilities, as well as the overall wellbeing of South Africans.

The organization was established in 1920, so we are quite old with the main aim to coordinate, monitor and promote services for persons with intellectual and psychosocial disabilities, as well as to promote good mental health and wellbeing amongst the South African public. Our mission I am just going to scan through that, is enabling people to participate and identify community health needs and respond appropriately, develop equal caring services for persons having difficulty to cope with everyday life including those with intellectual and psychosocial disability, creating public awareness, striving for the recognition and protection of the rights for individuals with these disabilities and aspiring to contribute to a fair and just society.

As part of an exhibit, you also received a document with a heading called SAMAM. Just to give you a brief overview of the contents of this document, it mainly talks about a project of the SA Federation which is called the South African Mental Health Advocacy Movement in short SAMAM. It was established in 2007 in recognition of the importance to give persons with psychosocial and intellectual disabilities a voice. It also gives you a bit more information about the 4 year strategic plan which is aimed at developing and strengthening advocacy service user movements across South Africa and the

plan runs over 4 years where we target on average 2 provinces per year starting with those most neglected.

Last year, we have completed site visits to Northern Cape and Mpumalanga Province and more to the back of this document, you will see a few graphs which were the highlights of the outcome of the site visits where we also do empowerment sessions with mental healthcare users as well as mental healthcare workers in areas of that province.

If you look, it was quite remarkable to see how many when we tried and tested the knowledge of the diagnosis of the service users, how many of them actually knew their diagnosis, was less than 65%, so none of them had an idea and it was never explained to them about their condition, what symptoms they have and the same goes for treatment. A lot of them did not know what treatment they take. They know how it looks and when to take it, but never actually know the names and what it is prescribed for.

The knowledge of what the mental healthcare users know of their human rights, was extremely low and even very little of them actually know where to report human rights violations. There is another graph on Page 8 that shows stock-outs. Stock-outs was reported in most of the clinics by most of the

service users, but the nurses indicated also that not all of the service users are aware of when stock-outs occur because they always seem to make a plan by borrowing some of the medications from other clinics in neighboring towns or communities.

Another graph indicates, you will see that the majority of clients that we deal with, access public healthcare services. Very few do access public services, you can see especially in the Northern Cape and Mpumalanga provinces. What was good to see, was the low reports of abuse or ill treatment in clinics and hospitals and we found that the clinic nurse, the psychiatric nurses at these clinics, they were very inspiring and they really carried the wellbeing of their patients to heart, so that was very good to find.

I know the survey and assessment that was conducted, look at the service users entire life, so just in relevance to mental healthcare, we found that the key needs that was highlighted in both provinces, for example in Mpumalanga highlighted a strong need of establishment of psychosocial rehabilitation facilities as well as independent living facilities. We found that a lot of them are abandoned by family members, the family members want nothing to do with them, so often when they are hospitalized and discharged and end up at

the door of the family, the family shows them away. They then end up on the streets where nobody is able to control their compliance of medication so it creates a revolving door syndrome.

For the Northern Cape it was interesting to find how the family dynamics was very different, in that they are more supportive towards their mentally ill relative, although they are not necessarily skilled to adequately support that mentally ill relative of theirs. In this case, the service indicated a strong need for activity groups that could stimulate them, because at the moment they are just mainly sitting at home doing nothing. The unemployment rate is also extremely high in that area.

That is just a brief overview of that report. I will continue with my presentation. I think it has been indicated that for the most part, mental health is a neglected health issue and because of the nature of the condition, leaves patients who suffer from mental health problems in need for protection.

If you look at the private to public healthcare referral, in the experience of many private healthcare service users, there is a, disconnect between the public and private services. For example, when a person accesses the private

healthcare services and their medical aid runs out and needs to be transferred to the public sector, there is often a disconnect between the 2. They are either indicated that they need to start at the primary healthcare level despite the diagnosis already been made by the private sector.

In other words, the public healthcare services providers will not accept the diagnosis from the public health sector. This causes severe delays in treatment and is also a waste of resources. These delays usually mean the patient goes without treatment while waiting to access to be reassessed and re-diagnosed in the public sector. This needs to be addressed to ensure continuous access to healthcare.

JUSTICE NGCOBO What is the suggestion here? Is the suggestion that because these individuals have been diagnosed and assessed at the private sector when for some other reason, they have to continue the treatment at a public facility. Medical practitioners at the public facility should assume the accuracy of the prior diagnosis and simply work on the basis of an existing one without satisfying them that it was accurate?

MS SUNKEL Yes because often when they go, they already got that twenty one days, so they have already received a diagnosis, been treated and

being stabilized. They just need extended care in that hospital, but because the medical aid runs out, that means that they need to go to public. The public need to accept the diagnosis and treatment plan wherever possible and continue the care from there on.

JUSTICE NGCOBO The medical practitioners at the public facility, don't they have the responsibility to satisfy themselves that the diagnosis, the previous diagnosis, the assessment was accurate?

MS SUNKEL Yes I think they can still do that in the tertiary care if they receive the reports from the public sector, they can still assess from there and still observe the patient that is already there now, instead of starting at primary healthcare level and continuing from there.

DRS VAN GENT Do you have any idea why doctors don't accept the diagnosis from the private sector? What reason is behind that, not following the diagnosis?

MS SUNKEL To be honest I have no idea.

MS CHAMBERS It is normally a number of reasons. A lot of it is the negative attitude well you were coming from private and now you coming to

State and why must we then take care of you and assist you, so we do have that negative attitude towards more private patients who have gone to State and a lot of it has to do with the internal processes of each hospital and we understand that. You can't take a private persons script and dispense it in a State hospital, but often through their own limitations, it makes it very difficult for that patient to access the care and treatment from a treating doctor.

JUSTICE NGCOBO I thought that it is one thing to be concerned about the delay that is going to be brought about by reassessment and re-diagnosis, but it is a totally different concern to suggest that those who are at a subsequent facility, simply have to work on the basis of the accuracy of what has been done before without satisfying themselves that that was an accurate diagnosis and simply continue with it.

MS SUNKEL If that person is now in tertiary care, the psychiatrist will have the opportunity to have sessions with that patient and will also then be able to reconfirm or disagree with the diagnosis. Just to continue, if you look at the recommendations that we would like to make, is to ensure that there is effective referral structure implemented between the public and

private sectors in cases where clients need to be transferred between the 2 for access to adequate healthcare services.

The objective of specifying a set of PMB's is laid out in Annexure A to the regulations of the medical aid schemes act, is to encourage improved efficiency in the allocation of private and public healthcare resources. So the delays and repetition of services is an insufficient use of healthcare service resources.

If you look, SADAC already mentioned the limited hospitalization of twenty one days. When you have a mental illness especially the more complex mental illnesses, it often takes longer than twenty one days to fully recover. I have come across cases where individuals with medical aid will cover only for the twenty one days but they needed more, so they actually went and took out personal loans, the one woman took out personal loans twice and so the financial stress on her because of the repayment of that just makes her symptoms worse and her recovery process is delayed.

The recommendations that we would like to submit is to allow the patients transfer from private psychiatric hospitals directly to tertiary facilities. This will decrease the burden on the primary healthcare system and to relook what

the standard minimum benefits relate to when it comes to bipolar disorder and schizophrenia. As per the general regulations to the mental health aid schemes act, bipolar and schizophrenia are identified as chronic illnesses in the prescribed minimum benefits list to which hospitalization is limited to 3 weeks a year.

Regulation 8.1 states that any benefit option that is offered by a medical aid scheme, must pay in full without co-payment, or the use of deductible's the diagnosis, treatment and care costs of the prescribed minimum benefit conditions. So the limitation placed on hospitalization of mental health conditions deprives patients of the right to full treatment and care cover for a PMB, 3 weeks is often insufficient.

Then discriminatory exclusion of psychosocial rehabilitation services, we often find that a lot of the medical aids do cover rehabilitation services for persons with physical disabilities, but they seem to exclude psychosocial disability and it is not recognizing it as a benefit that should be covered.

Psychosocial rehabilitation services are not offered by private or public hospitals, it is mostly offered by NGO's that run such facilities and in most cases, it is funded and registered with the Department of Health.

Psychosocial rehabilitation services are very important in the recovery process of the person especially when that person is discharged from a hospital and needs a step down to be re-integrated into society.

Annexure A to the regulations of the medical aid schemes recognizes that medical practices are constantly changing and that the impact effectiveness and appropriateness of the prescribed minimum benefits provisions should be reviewed accordingly. The regulations provide that a review shall be conducted at least every 2 years by the Department and that will involve the Council for Medical Schemes, stakeholders, Provincial Health Departments and consumer representatives.

So this mechanism for reviewing PMB's is incomplete as it does not make provision for reviewing the changes in medical care and precipitates the neglect of treatment options that have become available for diseases that have previously been sidelined.

MS MUVANGUA Ms Sunkel please excuse me, time is a bit against us at the moment. I have seen the presentation you gave us and most of these recommendations are in there. I wonder if it is possible to wrap up a little bit?

MS SUNKEL Yes sure. I will just run over the last few. With the essential drug lists, we have noticed that there is a bit of a misunderstanding or it is unclear what the functioning and the composition of the EDL committees are in relation to the criteria used when decisions are made of what medications should go onto the EDL list and which should be removed.

A lot of the service users become very distressed when they find that the medications aren't available at clinic level anymore and often it is not explained to them why exactly and what it is substituted by.

Then of course the stock-outs, SADAC already mentioned that, that it is a huge problem, there is a risk of relapse and we often find that a lot of those service users who are working and did not disclose their mental illness to their employer and relapse as a result of this, it has a domino effect on the rest of their lives, thank you.

JUSTICE NGCOBO The review mechanism that you referred to, which is required to be initiated by the Department of Health every 2 years, do you know whether these have been done in the past, these reviews?

MS SUNKEL No.

DRS VAN GENT Can I follow up on that question it is a very important one.

JUSTICE NGCOBO I beg your pardon, you make the statement here that this mechanism for reviewing PMB's is incomplete as it does not make provision for reviewing the changes, medical care and precipitates the neglect of treatment options. How do you know that if to your knowledge they haven't been done?

MS SUNKEL I am speaking to Section 27.

JUSTICE NGCOBO Does that conclude your presentation, yes thank you so much. Is this Mr Mdletshe who is next? Okay we are anxious to ensure that we complete all the Section 27 presentations before we break for Lunch. So you are the last presenter as I understand, so shall we hear what you have to say?

MR MDLETSHE Thank you Chairperson my name is Patric Mdletshe I am the National Deputy Chairperson of the Treatment Action Campaign. The Treatment Action Campaign is a member based organization that advocates for the rights and the interests of people living with HIV and affected with

HIV and TB.

We have two hundred and thirty branches and we have eight thousand members throughout South Africa. We have a long standing interest in the medicine pricing in ensuring the access to affordable medicines. The high price of medicine is a problem that affects both the private and the public healthcare system. As such, the cost of medicine must be a crucial part of the Competition Commission inquiry of private healthcare.

The TAC has successfully used the Competition law and other mechanisms in the past in order to ensure the access of the key medicines. We will actually highlight these just now. Chairperson in 2001, we fought on the side with the Government in so called the PMA case which the Government was taken by thirty nine pharmaceutical companies into Court, because of the 1997 medical aid and related substance control act. This particular act looked at 3 portions. The first part of it, it was actually allowing the doctors to prescribe a generic medicine once if the patented drug is actually expired. The second part of it looked at the importance of the generic medicine and the last part of it it looked at the transparent medicine mechanism.

Despite all this being signed into law, the pharmaceutical companies and the manufactured association attempted to stop this Act. The companies eventually dropped the case following the prospect of the dying people hence we know that there were a lot of people who were dying in 1998 moving forward due to the unavailability of treatment.

Chairperson in 2002, one of the most important victories we won in the Constitutional Court case, compelling the Government to provide the antiretroviral drugs preventing mother to child transmission. One of the arguments that was brought by the Government into Court, was that the treatment was going to be very expensive, which indeed it was.

Again in 2002, we also lodged a complaint with the Competition Commission regarding the excessive pricing of the 3 antiretroviral which was GlaxoSmithKline and Boehringer Ingelheim. The drugs specifically were AZT, [Lamovidine] and Nevirapine. At the time of the price of the antiretroviral was over R2000, but today the price has reduced significantly.

In 2003, the Commission found that the evidence supporting the allegation, the matter was referred for the Competition Tribunal. As a result, the companies settled and provided a voluntary licensing. For the Competition to

make cheaper generic in South Africa and other countries in Sub-Sahara Africa, the price of the first [indistinct 1:35] came down significantly. Today at least we are speaking about up to R100 or just less than R100 per monthly supply treatment. Many local and international experts made submission to the Competition Commission in this case. We urge you to visit this submission.

The manufacturers fixed those combinations that would simplify the treatment, helping people to better adhere on treatment, hence we understand that there was a treatment burden back then. In the case that they dropped in 2008, when 4 generic companies were licensed, produced it. This led to an 80% drop of the cost of the [indistinct 1:36]. Unlike the [Hazel Dow] case, was not referred to the Competition Commission. TAC believed that this licensing was granted due to the pressure that was created by the Competition Commission.

Again Chairperson in 2009, the Competition Commission invited the input from the trade management campaign to consider the merger between the GlaxoSmithKline and Aspen. Our complaint identified the competition for the antiretroviral medicine [indistinct 1:36] will be impacted by the merger.

This is commonly used by the treatment of infants and children with HIV. Based on the input of the treatment management campaign, the rule that the conditions of the merger, GlaxoSmithKline was required to grant license for the generic production of [indistinct 1:37], the price of [indistinct 1:37:04] halved in the 2011 ARV tender if you compare that to 2008, the initial price.

MS MUVANGUA Mr Mdletshe might I interrupt you here, we have the presentation and it seems to me that your concern might be around price. Is it possible to perhaps just tell what it is about pricing that the TAC would like the inquiry to hear about?

MR MDLETSHE Generally we feel that if you actually look into all these Court cases that I have alluded on, they simply saying that we have been very much busy being back and forth fighting the pharmaceutical companies to reduce certain prices, but without this being regulated, then probably we wouldn't be where we are today, so we are asking this Commission to further look at how can we work better in terms of regulating the entire industry at once, probably alert my colleague to add.

MS RUTTER I am also with the TAC. Just to say that the high cost of medicines is very prohibitive to accessing medicines both in the public and

the private sector. So particularly in the private sector, often medical schemes will just refuse to pay for certain treatments, you have to pay out of pocket if you are lucky enough to be able to afford that level of treatment, or you would just have to go without.

If you have to go without a certain treatment, a particular newer better medicines which are coming out now, you might have to stick with the medicine that has a worse safety profile, a worse efficacy profile and that isn't going to treat you as well as the newer medicines, so it is of grave concern to us that we ensure that medicine pricing isn't excessive in the first place, so we were highlighting these cases which is the only reason that we have been able to ensure the big public ARH program that we have today, is because of these cases and if we didn't have the competition which had to the huge drop in prices for ARV's in particular, then we wouldn't have access to these and that is what we are seeing with the newer medicines that are coming out now where we aren't having access to them.

MS MUVANGUA Thank you.

MR MDLETSHE Again Chairperson, in the case that the generic companies has resulted in the massive reduction in the prices of antiretroviral

medication in South Africa due to the large success of this Competition Commission cases in South Africa, the Government has availed to afford the massive AIDS program that we have. Today we are speaking at least of 3.6 million people that are on ARV's, which in one way or another that is good news.

Today, we are speaking about two hundred to three hundred thousand people that are on ARV's in the private sector. It is this clear that the Competition law and the Competition has played an important part in determining the price in South Africa and ensuring that the accessibility of medicine. While we have won important victories in relation to the certain antiretroviral medication, the prices of many medicines remain out of reach, for many, both of the private and the public healthcare system as well.

We are concerned about the high prices of the important ARV's like [indistinct 1:40] which is actually presently only used for the third line regiment. We know it very well that at least if it was accessible and cheaper, it would have found its place on the first line regiment. It is a very expensive drug and not accessible in South Africa and it is still a challenge to find its way to the first line. At least we know that [indistinct 1:41] also it works

very well to suppress the viral load much quicker with also very mild side effects.

Also we are very much concerned about the TB treatment. If you look at South Africa right now, we have a high rise of multi-drug resistant in TB. We are therefore concerned about the high price of the new medicine for treating TB resistance. This particular concern gives an increased rate of drug resistant TB in South Africa and at the moment, we are only able to treat half of the people than what we should.

Also Chairperson we are very much worried about the cancer, high prices of various cancer medicine. I think my colleagues here they have actually done very well in that regard to highlight all the challenges in that regard. We are aware that we cannot keep up getting involved in the extent Competition Commission cases. We simply do not have the capacity to keep taking the medicine cases to Commission. We want to stop fighting these individuals' battles. There must be a greater reform of this system to ensure that the medicines are affordable and are available for people who need them.

We have thus taken a strategic decision to campaign to fix the problem upstreaming by the advocating for the changes in South Africa patent laws.

South Africa can, in terms of the international law, have changed into the patent laws to better balance our people's right to access to healthcare with the private interest of the pharmaceutical companies.

We believe that Section 27 of the Constitution in South Africa places an obligation on the State to make such legislative changes. We strongly urge the Government to utilize all the public health safeguards as outlined in the 2001 Doha Declaration to ensure the better access to medicine in both public and private sectors.

We are also aware that the medicine pricing are also to some extent regulating in South Africa particularly through the regulation of annual pricing increase. We have also over the number of years private submission on a multiple set of the draft regulation for the benchmarking of the medicine pricing in South Africa against the medicine prices in other countries as yet in the international benchmarking regulation have come into effect.

While we appreciate the effect that some degree of the price regulation, we would like such regulation to be more transparent and also to allow the greater price intervention, the public interest demands it. We recognize that the patent laws reform the regulations of the medicine price may not be

central concern of this particular hearing, we do however urge the Commission to deal with the issues of the medicine pricing in all its complicity. We specially urge you to take note of the following: (a) the Competition Commission history in relation to medicine pricing in South Africa (b) South African outdated patent laws (c) other pricing control mechanism in South African laws. We understand that the Competition should be allowed to make a reasonable profit, but we think it is unethical to allow companies to make excessive profit while people cannot access lifesaving medicine.

In addition, the Constitution of South Africa places an obligation on the State to take legislative and other measures to progressively realize this right to access healthcare. This obligation extends to the pricing of medicine since our lives and health depends on it, I thank you.

JUSTICE NGCOBO Thank you Mr Mdletshe.

MS MUVANGU We have no questions Chair.

PROF FONN Can I ask 3 questions just to be clear. If I understand you correctly, what you are advocating is that there has been an in-principle

lesson learnt in relation to the HIV drugs that could be applied across the board and that you are urging that someone potentially us, should be looking at that. Am I understanding you correctly?

MR MDLETSHE Correct.

PROF FONN And then the second question is do you believe, is it your belief that the existing single exit price and the way it is managed, is adequate or not and that is what I am not clear on, so that is the second question and the third question is is what you are saying is that the Competition law has been used in such a way as to at least bring down drug prices and can principles from that, then be used to look at bringing down other prices that are not drug related that hospitals, are these the points that you are making?

MS RUTTER So on your second question, so what we are aware of is that every year, the Minister publishes the percentage of increase that medicines can go up by and that is the price regulation that we have, but we are not aware of nay kind of price regulation of companies coming into the market, they can set the price of medicines at whatever they see fit and that is why we are seeing half a million rand for a cancer treatment and mental

health treatments that are thirty five times higher than they are in India for example.

So what we are talking about, is the international benchmarking, which could potentially be one solution to having these dramatic differences in prices from South Africa to the rest of the world, because when we look at a lot of comparisons say between India and South Africa, we are paying horrendously excessive prices compared to them.

Sorry what was the third question?

PROF FONN I wanted to understand if you are making the point or not that the Competition law had been used to bring down drug prices in relation to HIV and that there were lessons from that for prices across the medical industry?

MS RUTTER I think what we are seeing, is that we fought that these individual drug battles all the time and without those cases, I mean when ARV's first came in, they were $10 000 per person a year whatever that is down to a R100 per person and those drops were only made available because of the generic competition and what we want to see is rather than having to

next go with a cancer drug to the Competition and then next go with a diabetes drug and then next go with the next big thing. Is regulation and reform of the entire system from the start so that we don't have to fight all these individual drug battles to try and ensure that people have access to the things that they need and deserve, that it is already regulated both legislatively and through regulation at the beginning so we are not having to fight all of these battles.

PROF FONN I am asking you if you think that there are lessons from that that can be applied outside of the drug area and to other areas?

JUSTICE NGCOBO The case that you referred to that was in the Constitutional Court in 2002, was that a case concerning the pilot projects that were run in the provinces which limited the supply of Nevirapine to areas falling within the project areas?

MR MDLETSHE Yes Chairperson.

JUSTICE NGCOBO The drug in that case, the company that manufactured the drug was willing to supply that free, is that right?

MR MDLETSHE That is true.

JUSTICE NGCOBO So there was no issue about the cost on the Government side?

MR MDLETSHE That is a little bit tricky right now, because my memory is a little bit rusty, but if I remember back then, ARV's were way too expensive and actually the point that was made by the Government back then, only one part of it was valid, but however we needed to balance the two, whether we were going to be worried about money or either save the lives of people. It is for that reason the Constitutional Court then ruled to say they needed to implement the PMTC program.

JUSTICE NGCOBO The cases that were brought before the Competition Commission beginning with the [Dawu] case all the way through, those were cases that concerned a campaign by the TAC and others to allow manufacturers of generic medicine to be able to manufacture those at a percentage that is much lower than what was being asked by the patent holder is that right? So that is what was achieved, is that right? Now none of those cases ended up before the Tribunal did they? They were all settled, is that right?

MS RUTTER One went to the Competition Tribunal, but they settled out of Court.

JUSTICE NGCOBO Given your experience in those campaigns, have you given consideration to how your experience with those campaigns, could be applied to the situation that we are facing now?

MS RUTTER I think that what we have learnt, is that the TAC doesn't only care about HIV and TB. We care about all of the healthcare portfolio and what we have learnt, is that it is unsustainable to work on this case by case basis and if we were just using the international safeguards that were allowed to us as a country, then we wouldn't have any of these problems in the first place.

JUSTICE NGCOBO As I understand from this campaign, the one thing that you did illustrate, is that it is possible to make use of competition law and policy to enhance access to essential medication. Now the question is have you developed a strategy based on that experience which would enhance access to healthcare in general?

MS RUTTER I think our [indistinct 1:53] shifted to a reform of the

entire system as opposed to using Competition law again and again.

JUSTICE NGCOBO I understand thank you.

DR BHENGU Judge to follow up, obviously those were granted or facilitated by the voluntary licenses which were product specific. The question I am asking now, is that one of the lessons, could it be that maybe it would have been better to not settle out of Court purely from a perspective of making sure that that agreement that compelled the voluntary licenses are actually effected in perpetuity because it means that you almost always have to negotiate product by product. I think the issue is that whatever the agreements that enabled the reduction in prices, the competition on generics, are clearly not applicable for the new products which may not even be products of the manufacturers which whom we negotiated in the past.

MR HEYWOOD Chief Justice if I could just step in and assist here, I was part of the team that was involved in those Competition Complaints and I think what is relevant here is that there is no doubt that if we pushed forward and got a judgement of the Competition Tribunal, that a binding judgement on these issues would be helpful, but as is the situation now, we were faced with the fact that a lot of people were dying because of the denial to access to

medicines as we made that complaint and therefore tactically it was better for us as Section 27 and the treatment action campaign at that point, to reach a settlement with the pharmaceutical companies that allowed generic competition which as we anticipated, led to very quick drops in the price of those essential medicines and the affordability of those medicines through both the private and the public sectors thereafter, so it really just in a sense, confirms what my comrades here are saying, that we could have trench warfare under the Competition Act regarding the costs in private hospitals or regarding the costs of certain specialists.

We could adopt exactly the same approach that we adopted with access to essential medicines which is to argue that you have to read competition law in the light of Section 27 and other parts of the Constitution and that Competition law should assist access to healthcare services rather than hinder it. We could do the same research which the Department and others have done to show that there is a disconnect between the investments into some of these healthcare services and the prices which are charged to the consumer of those healthcare services, so I think many of those same arguments could be brought, but as you have heard from the whole array of partners and clients of Section 27 and we could bring you another three hundred people to tell

similar stories, people are suffering now and we are looking for systemic change and for the inquiry through its investigation to be able to make recommendations that can bring change across the spectrum to these problems.

JUSTICE NGCOBO Does that conclude the presentation of Section 27?

MR MDLETSHE Yes Chairperson.

JUSTICE NGCOBO Okay very well thank you.

MS RUGEGE My apologies we have Mr Ivan Evans who is on our list. He is assured me that he would like an opportunity to speak for just 5 minutes. He has travelled quite some way to be here and would like to be heard very briefly.

JUSTICE NGCOBO Yes let's hear him.

MR EVANS Good afternoon as you heard my name is Ivan Evans. I have been living with HIV since 1991 when I was diagnosed and as many of us know, it was a time of a lot of ignorance and hysteria and expensive medication, so I looked around because I wanted to live and I started doing some research and I found that the only way I could afford any kind of

medication, was to put myself onto treatment trials. As we know, we haven't developed an effective vaccine as yet, so because of those medication trials, I was able to get free medication, but the dark side of that story, is that as a result of the trials, there weren't many medications at that time.

I think AZT was the main one and then we tried out the so-called new ones and I developed side effects. The main side effects I developed was lipodystrophy which was the growth of abnormal fatty tissue around various parts of my body. The main one that was giving me a lot of problem was the thing called [Buffalo Hum] it is a big fat pad of tissue on my neck and around various parts of my body, but I then applied to my medical aid for assistance with getting treatment.

I went to see a plastic surgeon, he made a very good strong motivation, submitted it to the medical aid company that I have been giving money to for a long time and then they declined it. Then I thought okay because I was in a privileged position, I knew some of the organizations because of the nature of my work then, I went to see the treatment action campaign. At that time, I didn't know they had changed to Section 27.

Then we started instituting legal action against them, but before all that happened, I decided to go and have the operation anyway, because I was having a lot of problems with sleeping and headaches and things like that and so I paid for the operation myself, it was quite expensive, it was about R11000 and then I thought no I cannot let them get away with it, so I went to see the Section 27 people and we got the medical aid to pay back the money.

My main concern was that they were very cynical about it, because as far as I am concerned, they said they never received the pictures from the plastic surgeon. He wrote a very strong motivation sort of lauding me as one of the pioneers of medical treatment in South Africa and then they said they got the motivation but they did not get the pictures. I don't know how they couldn't have gotten the pictures but anyway I got my money back eventually, so I just thought I would tell my story to all of you so that you can see that I am one of the many people that has probably been done in by the medical aid.

In general they have been very good, but as far as certain kind of procedures are concerned, they just don't want to budge, but I felt that they were very cynical because afterwards I got a phone call from them asking why I took them to the lawyers and I said to them well you didn't want to pay me, you

didn't want to pay for the procedure, so I wanted my money back. So that is my story thank you.

JUSTICE NGCOBO Thank you Mr Evans for sharing with us your story. Does that conclude the presentations of Section 27?

MS RUGEGE Thank you that does conclude our presentation and we would like to thank the panel for this indulgence and time thank you.

JUSTICE NGCOBO Now this morning there were additional documents that were handed to us. It is not clear to me whether these documents form part of the record that has been published on our website, but if they do not, may I please urge Section 27 to make sure that the additional documents that were referred to today, form part of the record of your submissions so that they can be reflected on our website for everyone to see. The one document that comes to mind is the additional document presented by the South African Federation for Mental Health which was referred to by the speaker from the Federation of Mental Health which contains the strategic plan I think it is.

The other document is a Section 27 magazine which is a patient story handbook, the Heart of the Private Healthcare and then the other document is

the treatment action campaign oral submission to the Competition Commission. To the extent that we don't have any of these, that these have not previously been submitted, would you please make sure that all these documents are submitted to the technical team so that they can form part of the record so that they can be published on our website.

MS RUGEGE Thank you Chair we will do so. We will also provide the technical team with the additional documents promised by Mr Eagar and some of the other speakers. We would also to perhaps prepare a short written submission in answer to some of the questions that were raised during our presentation.

JUSTICE NGCOBO Thank you for making time to make the presentation and for bringing the members of the various groups to come and talk to us on the experience with the PMB's in particular and the medical schemes in general, thank you so much for your presentation.

I am afraid we are running out of time and the next presentation that we would like to hear is by the World Health Organization. We are going to take the Lunch break at this stage and perhaps have a very short Lunch break until about 2:30 so that we can get on with the next presenters on time.

[END OF SECOND SESSION]

[START OF THIRD SESSION]

JUSTICE NGCOBO The presentation that we are about to have, will be made by on behalf of the World Health Organization and the Organization for Economic Cooperation and Development. You will then indicate who is going to start and the organization that you represent and then of course if you could just state your name for the record, thank you. Are you ready to proceed?

MS BARBER We are Sir. Good afternoon I sincerely thank the Competition Commission and the honorable panel members for giving us this special opportunity to present a study that the World Health Organization commissioned with the OECD. Our team here includes Francesca Columbo, who is the Head of the health division at OECD, Luca Lorenzoni is the Health Economist with OECD and Tomash Rorbal at the end, is a Health Economist with the World Health Organization and I am Sarah Barber with the WHO a representative in South Africa.

With your permission, all of us will present different parts of the study,

starting here with Francesca.

MS COLUMBO Thank you very much for the opportunity to be here, let me start by saying why are we looking at the private sector and the obvious answer is that it is because an important sector because it is huge and to illustrate that, I would like to show this slide which really looks at the sides of the private voluntary health insurance markets in South Africa all on the left, relevant to other OECD countries as well as some of the emerging economies and as we see here, the South African market is the largest, it accounts for more than 40% of total health expenditure relative to an average for the OECD countries of only 6.3%.

So it is 6 times larger than what we find in OECD countries. Perhaps what is unique, is that this large market covers a relatively small part of the population, some 16% of the population, so it is really a large investment, a large use of resources going to a relatively small share of the population which can raise questions about equity.

Just to take another look closely at the role the private health insurance plays and we know that private insurance is the main payer for private services. In South Africa, this is somewhat unique, but also similar to other OECD

countries. It is unique in that many OECD countries have private health insurance role which supplement or compliment what the public system covers. What I mean by that, is that often private insurance covers services which are completely outside the basket which is covered by public system such as cosmetic surgeries, or it may compliment the cost by covering a share of the price for that.

In South Africa, the coverage we would define that as being duplicate which means it offers the same type of services you find the public system but through an alternative providers, through private providers. It is a type of cover that we do find in other OECD countries.

There is Australia as well which is not highlighted but I would like also to mention that there is Ireland there is New Zealand, Portugal Spain. Perhaps what you can look at that is that some of the markets for these OECD countries can be quite large in terms of the population covered. If you look at Ireland for example, it covers about 44% of the population or Australia, 50% of the population, but the share of the total health expenditure accounted for by private health insurances, is much lower in those countries compared to

what happens to South Africa.

So quite a large market, which means it can have quite a significant influence and impact through various spillovers into the public sector and that is important to highlight. Another aspect which is quite unique of South Africa relevant to OECD countries, is that most countries across the OECD, have some mechanism to sort of set or to define what are the prices for services, health services in the hospitals and the specialist sector.

So these are very important mechanisms which took quite some time for countries to put in place, but in a way, they can be considered as public goods. What I mean by that, is that they are used to provide a benchmark and in a way, norms for contracting. They can be used also as a way to encourage the transparency in the pricing and in the costs. They can be used by public funds to have an idea of how to link the different type of services which are provided to the budget and they can also be looked at by the private sectors to sort of have an idea of, what are the benchmark, for prices.

They do not exist in South Africa. They are being used in OECD countries also as a way to enable contracting with the private sectors at prices which are quite transparent. What it means for South Africa, is that at the moment,

the prices that we, are the results of the negotiation between a handful, a small number of medical schemes and private hospitals, it means that these negotiations are really the ones that determine what a very large share of the spending of the countries is then used for.

So what we did in this study, we looked at different things and the results will follow. We looked at comparing private hospitals for South Africa with other OECD countries. We also looked at the correlations between those prices and the countries income. We looked at issues related to affordability of private hospitals in comparative to other general goods and services. Those who we collected a number of specific issues, which are only for South Africa, we don't have the data also for others OECD countries.

I would like to spend just a few minutes on the methodology. It is perhaps quite a complex methodology, but what I would like to stress and highlight, is that both our organizations, the OECD and WHO, they really are quite used to working with international comparisons. They are used to make sure that this international comparison are robust and that they are grounded into uniformed definitions into standards, into units which are applicable to the countries involved. We have followed really those procedures also in the case of these

studies.

We have used an approach which is applied and validated in OECD countries throughout many years, through a project which is called the OECD [indistinct 7:34] priorities projects. This involved the setting up of the task force, they met several times, this involved different meetings with countries where the different aspects of the methods were validated.

What these methods do is it summarizes 2 main things. First, it tries to define, what is a in-hospital product. By hospital product, I mean really something which is a complete product, so an output of a hospital services and we collect data for 7 medical services and twenty one surgical procedures, so for example, a medical service would be like normal delivery. A surgical service would be a C Section.

So we spent a lot of time to try really to define and make sure that we have something which are, cases which are representative for all the countries which can be used for international comparisons.

Next to that, we need to assign some prices to those typical cases and we have done that through a costing exercise which tries to take into account of all the

different components of the price, both of the overheads as well as the direct costs as well as the capital cost. So what we are doing, we are trying to assign a cost in the price to what are some typical cases, typical services which in OECD countries, are covered throughout this system and it can be provided by public or by private services. They are part of what is the general offered for people who are covered by the national health insurance of their countries.

We will also collect the number of information or admissions on average length of stays and for South Africa, also issues about the price components. About the data that we have used for these studies, we used data from medical schemes accounting for about 60% of the members of the medical schemes and they total over six hundred thousand cases.

For OECD countries, this is part of something of regular data collection that we do and which is used for international comparisons as part of the purchasing power priorities project that I mentioned about. The data specifically for these studies refer to twenty countries and we have done 2 benchmarks, you will see in the results. One is in relation to all those countries and the other one is in relation to a subset of countries which have a

GDP level, so income per capita lower or it is more comparable to what happens to South Africa.

I think quite importantly, we have done an awful lot of consultations with some of the people which are here really to make sure that we got things right and we have done it for example working with [indistinct 10:38] South Africa which really have work, provide the experts they worked with us, with the OECD experts to adapt the methodology to South Africa. We have also tested the methodology with GEMS. We have shared the data with a number of the medical schemes with GEMS, Medi Scheme Holdings, with Bonnitas, we have also made sure that the preliminary results could be shared and discussed openly so that we could make adjustments in proving the accuracy and proving the robustness of the work.

For all of that, I really think on behalf of the team, we really would like to thank all these organizations, who gave very generously their time, they shared their expertise. It has been really a tremendous process.

So once we have defined the products, once we have costed them, we need to make sure that the data are international comparisons and for that again, we

use something which is an international standardized methodology which we need to convert into purchasing power parities those data.

The results are then reported in relative terms. We have results on price levels to facilitate the comparisons, we calculate what is the average and put that as equal to a hundred and we then look for each country, the distance from this hundred, so for each country, we have a comparative price level which is expressed really in relationship to the mean of hundred.

We do take account of things such as exchange rate fluctuations, this is [indistinct 12:26] in the methodology because they are captured both in the definitions of the inflation and in the definition of the hospital prices. With that, I think it is probably time to look at the results, which I will pass onto my colleague.

MR LORENZONI Thank you very much, good afternoon everybody. We first present prices for hospital services in South Africa. Again we put South Africa in the international context and compared also affordability for hospital services in South Africa and finally, we will see whether we could explain the differences in hospital prices through factors, drivers, who could tell us what is driving prices in South Africa.

These lines show you the list of medical services we priced in our study and you see that we present figures for South Africa in Rands, so national currency and we look at the trend over time and for each of the hospital products provided by private facilities, which were under contract with the medical schemes, we included in our study, you can see that there was also an increase in prices over time by comparing 2012 against 2011 and 203 against 2012.

So the increase in price in the average price observed across providers, South Africa ranges in between 4.6% for the malignant [indistinct 14:25] to 10.7% for [indistinct 14:29]. We observed the same trend for surgical services provided by private facilities. Here is the complete list of the services, the products we focused on in our study, the twenty one surgical prices and again, we observed an increase in the price over time, ranging between 3.9% and 9.1%.

So the first evidence we got from the data that we received from medical schemes, is that over time, there is an increase in prices for hospital services provided by a private facility and this increase is higher than inflation, so general prices grew as measured by the consumer price index. In this slide,

we present through a bar chart, the trend over time, keeping in mind that we also observed over time, an increase in the number of cases, so if we take into account the number of cases which were provided for those twenty eight products hospital services, we observed that in total, there was an increase of 6.8% of price from 2011 to 2012 and an increase of 6.2% in price from 2012 to 2013, which is higher as compared to the inflation or to the general economic price growth as measured by the consumer price index which was 5.6% and 5.7% in 2011 against 2012 and 2012 against 2013.

We also saw a difference in the trend in prices for medical services as compared to surgical services, so somehow there was a bit of a higher increase I may say in medical services as compared to surgical services. What if we put South Africa into an international context? As you can see from this slide, what we tried to do is to compare hospital prices, so hospital prices for private facility against the GDP per capita which is a measure of income.

There is a strong correlation in between the vertical axis where we report as index hospital price level, one hundred is the average across most of the countries and the GDP per capita varies which are reported on the horizontal

axis. The high correlation which is 0.82%, so what we could see from this slide, is that prices of hospital services are not in line with what could be expected given the GDP per capita, so the income level of South Africa and this is where South Africa sits on the left of this chart which tells us that South African prices of hospital services provided by private facilities, are on par with countries, France, United Kingdom and Germany, countries which do report a higher income level.

Then we compare hospital price level for private facilities against the price level for the general economy, so prices for goods and services such as food, clothes, mobile phones to see whether the 2 levels are different across countries and as you can see from this slide, we reported the line, the red line reports the difference in between the economy, the general economy price levels, so goods and services that households consumed in their everyday life while the bar chart represents the hospital price level, so South Africa is to the extreme right of this distribution which tells us given that it is zero, again that South Africa's price levels for hospitals, are much higher as compared to the price level for the general economy.

This somehow tells us that the environment, in which services are provided

by hospitals, is a different environment as compared to the general economy where goods and services are provided and consumed by the general population. Now let me go through some figures which could show you the main results of the study. In this table, we report the comparative price levels for hospitals and for economy, so the GDP over the 3 years.

So as an example, for 2011, the hospital price level is reported as being 108%, which means that we observe in South Africa for the representative sample of hospital services provided by private facilities, a price level which is 8% higher as compared to the OECD average which is 100%, so it is an index. Then the same is true of 2012 and 2013, where there was a slight decrease, so in 2013, 103% which means, it is 3% higher as compared to the hospital price levels in comparative countries.

In 2013, we observed a decrease of the price level which is 6% less as compared to the OECD average which is represented by the twenty countries that Francesca listed in one of her slides before. While on the other hand, if you look at price levels for the entire economy which includes as I said before, food, clothing, mobile phones, the price level for South Africa is 62% for 2011, 2012 which means that price levels are 38% less relative to the

OECD average of the twenty countries which is 100%, while they were 53%, so 47% less which is almost half of the price level observed in 2013 across comparative countries.

For your reference, we will also report that the bottom of this chart, the GDP per capital level for South Africa in the comparative countries. We also offer figures for medical services and surgical services which confirms that surgical services were more expensive as compared to the OECD average, 105% in 2013, so 5% more expensive as compared to OECD average while for medical services in 2013, hospital price level was 25% less as compared to OECD average.

What if we compared to the subset of 7 lower income countries, Czech Republic, Estonia, Hungary, Poland, Portugal, Slovenia and Spain, we see a similar trend in a sense that price level for hospital services are higher as compared to the lower income countries as expected because the value of 100% is nowhere as compared to the twenty countries we used before as a benchmark. So compared to the 7 lower income countries, South Africa in 2013, presented a price level for us, because services which were 92% higher as compared to the 7 countries benchmark, 192%. For the economy in

general, the price level is still lower as compared to the subset of 7 countries, 74% in 2013 which means again 26% less as compared to OECD average which was 100%.

So what we see is that results are consistent over time for South Africa, so the figures that we are reporting in relative terms, are consistent over time and also, if we compare to a larger subset of countries, on the one hand, we've got hospital prices which are on par with European countries, such as France, UK and Germany, while they are much higher as compared to lower income countries. The opposite is true for economy wide prices which are half the comparative country if we use the twenty set of countries while they are 25% less if we use the 7 lower income country subset. Again, the bottom line, there is a table which for reference, reports the value of per capita GDP in the subset of countries and South Africa.

Now we just wanted to look also at affordability of hospital prices, so this line shows you that if we compute and index which is based on the 2 price levels, the first one hospital, so hospital services provided by private facility. The second one economy price levels and if we compare the two, you see again there in terms of affordability of private hospital services in South

Africa, this chart suggests that there is a high and important gap in between the hospital services price level and the economy price levels, which makes South Africa the country reported to the extreme left of this chart, which somehow could suggest that there is this large difference between the price level for hospital services and the economy, the goods and services in their own economy could somehow question affordability of hospital services in South Africa.

Now we wanted to go one step further and we wanted to see whether we could somehow take into account the distribution of the population in South Africa and have an idea of whether those price levels are affordable for different subset of the population in South Africa, so by using data publically available from the Statistics South Africa website, with the income and expenditure survey 2010 to 2011, we were able to provide you with the distribution of expenditure per capita, so what a household consumes against the different income this size and so you can see in this chart which is similar to the one I showed before, on the vertical axis we have the hospital comparative price levels, they stay the same exactly.

While on the horizontal axis, now we report per capita expenditure, so we are

focusing more on household consumption and then we were able to link consumption expenditure to income this side, so there is this line for South Africa where looking at extreme right, a dot, a point that says South Africa this [indistinct 27:28] which means this is the upper income in South Africa while moving towards the left of this chart, we then also reported South Africa income [indistinct 27:43] ninth, South Africa income [indistinct 27:44] eighth and so on, so South Africa income this high eighth, which is a point saying SA this high eighth, it is almost close to the South African average and then we also included in this chart, the traditional points relating to the lower income this side, moving towards the left.

The point I would like to make is that there is a high correlation between hospital comparative price level on the vertical axis and per capita expenditure, so we are talking about household consumption on the horizontal axis and you can see that for the large part of the population, I might say 90% of the population, hospital prices are likely to be less affordable as compared to the other OECD countries. While on the other hand, we see that for the upper income, it is clear that they could afford and eventually, I think this is something that the Competition Commission could take into account, thank you.

MR ROUBAR Let me now turn to the factors driving the prices as Frencesca was presenting at the beginning, we were looking and examining the changes in the volume which we measured by lengths of stay and by number of admissions and we also collected data on the components of the price dedicated to specialists, pathology, hospitals and radiology.

We recognize that there are other factors which are also important as drivers of prices, including the organization of care and patient preferences, but we didn't investigate these details in our study. When looking into the average length of stay, the OECD averages are on the right hand side and the South Africa average is for the sample for which we have data on the left hand side.

So we found that the average length of stay in private hospitals in South Africa, is 3.3 days which is the green bar on the left side and which is 1.4 days shorter than the OECD average 4.7 days on the right side, the green bar. For surgical cases, they are pictured on your right. South Africa is again on the left. The difference is even larger. Average length of stay in South African private hospitals was nearly 3 days 2.9 days, which is 1.5 days lower in comparison with the OECD average of 4.4 days and the message similar

for the medical cases which are depicted in blue.

You can see that there is a significant lower length of stay in South Africa compared to the OECD average. This is true and these findings hold true also for all of the case types which we have investigated and on the slide you can see the medical cases where the average length of stay for medical cases and surgical cases together was between 8% to 41% lower and there you can see on the graph, the blue bar depicts the average length of stay of South African case types and the red one is the OECD average.

When we look into the admission rates, we found that there are no changes in the overall admission rate in the South African sample and this is represented by the chart on the right side where you can see that the rate of admissions per one thousand beneficiaries has been relatively stable over the 3 years so we don't see that there should be any significant increases in the utilization of admissions over the 3 years in the sample of cases which we had in our data.

What was striking for us, is that the structure of admission is changing significantly and over the 3 year period, there are some cases which increased by more than 50% and you can see on the graph again, the comparison between 2011 and 2013, 2011 is blue, 2013 is red and you can see that there

are some case types which are more emergency surgeries such as appendectomy or repair of hernia where you can see the increases are around 5% and 7%. On the other hand, on the right side, you can see surgical procedures which can be more planned, procedures such as hip replacement and knee replacement, where the increase over the 2 year or 3 year period, was 32% and nearly 54%.

We think that these large increases can be explained by changes in membership or aging of the population over the 3 years in the study and for the data for which we have information available. When we were trying to understand the admission rates in general, are high or low or the numbers when we wanted to put them into some international perspective, we found 2 case types for which we have data available where we could compare utilization on number of admissions and this comes from a different study published by OECD, we use the same methodology to calculate admissions just for age and gender differences to standardize population and we can see that in the case of hysterectomy, the admission rates are higher than many of the OECD countries.

When we now look at the price components of individual case types, we

would like to present it in some read out charts which show the components by colour, the green is the hospital share, the violet is the pathology, the blue is our specialist and red is radiology, so the graphs are now showing the medical cases and the component of the price and we found that the hospital components accounts for 40% to 55% of the price in medical cases.

In surgical cases, it is even higher, the share of the hospital component is between 49% to 62% and in both cases, it is surgical and medical cases, it is the largest component of the price and you can see it by the green line.

The second highest component in medical cases is pathology which is purple and this represents 21% to 35%. The share of specialists component in the price is higher in surgical cases, so here the specialist bull bar is more in the centre and you can see then later in the report, the specialist component of the price is actually higher in the surgical cases and the specialist component is actually in the blue.

When we looked into the changes of the components over the 3 years which you can see on this slide again for example, on the medical cases where you can see the year 2011 in blue 2012 in red and 2013 in green and you can see the green colour is usually on the outside of the blue and red which means

that the share of the component of the price devoted to specialists has been increasing.

We see similar increases of the share of the component of the price going to pathology as well. Therefore, we would like to suggest that the price increases over the 3 year period for which we have data in our study it is the pathology and specialist services which are the biggest drivers of the price increases in South Africa.

MS BARBER In summary, the strengths of the study were transparent and reproducible methodology which was tested and validated across the medical scheme data. Our hospital cases are comparable and they are clearly defined and they are representative of the kinds of services that hospitals typically provide. The price estimate is based on payments from the public purchaser. We note specifically that in OECD countries, the public purchaser or the government typically establishes the prices for services that are covered under the basic benefits package, therefore the price that the government pays for these health services, would be the same regardless of whether they are delivered in private or public health facilities.

This enabled us to accurately compare private hospital prices in South Africa with prices from both public and private hospitals in OECD countries. All costs were comprehensive and included specialists, nursing pharmaceuticals, pathology. When comparing prices, we used the international standardized method of purchasing power parities.

There are several limitations of the study. The comparison was done with countries for which OECD is currently collecting data from an ongoing project. The project has not collected on the cost components of hospitals and specialists for the comparative countries, so we can't tell you for example, the share of the price devoted to specialists in OECD countries. We cannot compare the prices for individual medical schemes and we cannot provide information about the market structure and its impact on prices.

We have 7 major conclusions from this study. First prices are high and increasing. South Africa's private hospital prices are expensive relative to what could be predicted given South Africa's income level. Prices are also increasing over time above the rate of inflation or at a rate higher than other goods and services in the economy. Second, prices are not affordable for most South Africans. Among all our countries in our study, South Africa

demonstrated the greatest difference between hospital price levels and price levels for other common goods and services available in the economy. Therefore, we ranked South Africa's private hospital prices as the least affordable amongst all the countries that we analyzed in our study.

In looking at the household expenditure levels, among the highest income South Africans, we find that the private hospital prices are likely to be expensive for 90% of South Africans. Third, the unusually low lengths of stay are probably as a result of cost control efforts. While we did not study this extensively, we do note with concern the exceptionally low average length of stay for South Africans in private hospitals across every single case type, which does suggest something more systematic and we believe this is very likely related to the financing and the organization of the care including weak controls over admissions and the application of certain cost control measures including specifically pre-authorized length of stay.

We believe that the impact of low average length of stay on quality of care and health outcomes are a concern and do suggest that there could be an area for future evaluation. Fourth, large increases in high volumes of surgical procedures cannot be fully explained by changes in membership, an aging

population or other external factors. Planned surgical procedures and specifically hip and knee replacements increased rapidly over a very short period of time. These changes do not correspond with the relatively modest increases in medical scheme membership. They also cannot be fully explained by aging population or other external factors and such a rapid increase does suggest that supplier induced demand is a factor.

Fifth, the hospital share of the component of the price, the hospital share of the price, is the main component, but specialist fees and also pathology do appear to be driving the increases that we see in our study between 2011 and 2013. The hospital component accounts for between 40% and 62% of the price, the lion's share of the price for all the cases that we studied.

The increases in the price observed in the study however do appear to be driven by the increase in specialist fees and pathology and we do believe this has implications for access. Sixth, the high prices in the private health sector spill over into the broader public health sector serving 80% of the population as well as the economy as a whole. Given the magnitude of private voluntary health insurance spending which accounts for 3.7% of GDP, these findings have implications well beyond the personal budgets of the small share of the

population that can afford them.

Market interactions in the private healthcare sector do spill over to the health system. The prices set in the private sector set labor benchmarks, specialist space in choosing to work in public or private health facilities, high private prices such as those reported in the study, will restrict the ability of the government to use private services to achieve universal health coverage under the national health insurance reforms and based on experience from other countries, increases in prices are passed on as increases in premiums to members and employers, which can then lead to individuals bearing the burden of these price increases through for example, higher co-payments, or reduced benefits.

Lastly, the current ways in which the private sector controls price, do not appear to be ineffective. The prices are high again relevant to other countries that we looked at and increasing. This does suggest that the current methods are not effective in curbing price inflation. We have noted that other OECD countries have measures to prescribe, cap or benchmark prices that South Africa lacks and the study finally concludes that efforts to control prices well ensuring accessibility and quality are needed which could help individual

South Africans and the country at large to get more value from their considerable spending on healthcare. I thank you very much for listening.

JUSTICE NGCOBO Thank you, does that conclude your presentation?

MS BARBER Yes it does.

JUSTICE NGCOBO Are there questions?

MR SELEKA Yes Chairperson I think the lady is Francesca I have a question for her. The issue of price regulation has featured prominently this morning and I see that you have in your presentation, referred to OECD countries having measures in place to benchmark the prices. Now if you were here this morning, you would have heard that attempts have been made or legislation provision has been put in place in South Africa to seek to achieve exactly that, but in the South African context, those provisions were not mandatory. How do the OECD countries compare to South Africa in that regard? Do they impose prescriptive measures or are the measures only used as guidelines?

MS COLUMBO It really depends on the country. Some countries it is really prescriptive, so that is the fee schedule, it is determined and that is the

one that is set for all the providers and the payers and that is the one that is used throughout. In some other cases, these set some sort of benchmark following which there is negotiation taking place between the association of providers of hospitals for example on the one hand or of a doctor on one hand and on the other hand, the purchaser, so there are multiple insurers in some countries.

Regardless of what specific models are used, which very often reflect the institutional features and the organizations of the system, what is quite clear is that these mechanisms do provide a very strong benchmark. First of all, because they are grounded in very sound technical measuring which really follows methodologies which are proven which allows it to be recognized by all the different players and they are really set as we mentioned the benchmark.

This is then used as the starting point for decisions about the level of the prices in some cases. There might be an extra step in some cases, which is more a process of negotiation between the different payers in some other cases, those are the prices and those are the ones that are set for the public

and the private system.

MR SELEKA One other question is in the South African context, we have had litigation in regard to prescription of prices where we have seen the Competition Commission intervening and having those tariffs set aside. In the name of impacting on competition in the health sector, what is the experience in the OECD countries in this regard?

MS COLUMBO So it is a difficult question and is a little bit outside of the scope of what we are presenting, but there is a very difficult balance in looking at negotiations that may take place between associations of providers on the one hand and the association of payers and insurers on the other hand, which are quite important because health is a sector which has significant market failures and which justifies the fall for the public goods having allowing this sort of negotiation to take place in a collective way.

Sometimes there have been cases in which these were not good in negotiation, but they were more of a concerted price setting efforts across between the providers and the payers and that is where competition authorities have come into play to seek to distinguish where there have been efforts which have led to not making the competition mechanism in the markets work.

So it is a very fine and difficult line to distinguish between what are worthwhile collective negotiation processes on the one hand and on the other hand, when there is concerted price fixing into these negotiations. It is very relevant to countries where there are multiple players obviously.

JUSTICE NGCOBO Can I, just make a follow up on the questions that have been put to you? Is it possible for you to refer to us to some research studies that have conceded various price regulation measures in other countries, which would indicate to us what are the advantages and what are the disadvantages of those measures, what type of measures are generally resorted to, the effectiveness or otherwise of those measures. Is it possible to do that?

MS COLUMBO Absolutely, there are studies that we have done which are not the object of the discussion today, but for example, we published a study that was done with the support of WHO specifically for South Africa. The title is Pricing and Competition in Specialist Medical Services, a review for South Africa, so it is a review of OECD countries' experiences for South Africa.

Another study that we have done looks at wage settings into the hospital sectors. I think we can make those studies at your disposal. They are definitely useful reference by looking at how other countries have approached these issues.

JUSTICE NGCOBO I did want to ask you a very basic question from a layperson's standpoint. It relates to your approach to the study. The first question relates to the use of OECD countries as a comparator. What is the validity of that comparator? Are there any pitfalls in using that? Are there other countries that one can look into in making these comparisons that you have come up with?

The other matter that I wanted to draw your attention to, is a matter which has been raised by some of the stakeholders in their submissions and it really relates to the role of the CPI. The statement that has been made is the following: inflation in private healthcare costs cannot usefully be compared with inflation as measured by the CPI. You do understand the statement? Now I would like you to comment on that statement.

Then it is followed by a further statement which also emerges from the submissions that we have received and it is this statement: the frequent use

of CPI as a comparator for medical inflation is accordingly subject to qualification, thank you.

MS COLUMBO Thank you I will respond to the first one and then I will defer the other questions to my colleagues. First of all, to say that we would be very happy to extend the analysis also to other countries, indeed we are looking at whether we can extend it to some of the emerging economies, the BRICS countries. The methodology that we have has been proven to be sound and robust internationally. We have collected the data for [indistinct 54:44] countries because that is where they exist, but their methodology is robust for international comparisons beyond OECD countries.

So the reason why we have presented 2 benchmarks is one looking at South Africa versus the OECD average and the other is looking at South Africa versus the average or subset of countries which are the lower income countries in the OECD. That is to give an idea of how do the results change if we look at the OECD countries as a whole and if we look at a set of comparative countries where the income per capita, is it more similar to South Africa. I would be delighted to extend it to some of the other countries.

JUSTICE NGCOBO You have referred to sound principles. Now what are the principles that one can rely upon in testing the validity of these comparators if there any, because I can imagine that we will be asking during the course of this inquiry to look at that and not this and I just want to understand are there any guiding principles that we should use that are accepted internationally that we can use to make a decision as to what is the most valid if there is a term such as most valid comparator?

MS COLUMBO I think the main issue like what we have done in the study, is to make sure that when we define the products, that it will be something that will be regarded internationally in countries which have very different diverse systems as something which is applicable to their reality, even recognizing that there are differences across countries, but they are sufficiently standardized, so I would stress the issues of the need for standardization. Once you have methods which are robust, which are agreed by many different countries where there are opportune ways to standardize where there is a clear transparency about both methodology and the sources of the data, when there is a lot of work that is done to perhaps even in the data, to clean the data, to take out some of the data, those that are excessively looking strange. So that it becomes as much standardized as possible.

Once you have that, you are on safer ground for international comparisons, so I would again stress and go back to the issues of the methodology but I would say the critical word here is the standardization of the methods.

MR LORENZONI We use consumer price index as just a reference in our analysis and so what we say is inflation is measured by consumer price index. The reason we did so is that we are trying to look at affordability and when you look at affordability, you should assess whether also final consumption expenditure, are related to hospital prices. That is what we did and so from a report from the Council for Medical Schemes for South Africa 2015, the report clearly says we suggest using consumer price index as a proxy for the [indistinct 59:35] because in the large sectors of the economy in South Africa, wage increases are linked to consumer price index changes, so this is why we used it.

DRS VAN GENT Thank you very much for your interesting contribution, I have a couple of remarks. First of all, for Mr Lorenzoni, can you give me Table 8 Page 23 again, where you compare price levels and GDP levels over 3 years, time? It is a sheet that he showed. In that table, you compare over 3 years, time, price levels of medical services, surgical services, hospitals all

together and you compared also to GDP price levels in South Africa.

What you have observed most probably more sharply than I have is that there is enormous decline in price levels between 2 years, between 2012 and 2013. Hospitals in total, from 103 level to 94 in one year, now unless I don't understand the table, what does this suggest about the robustness of your figures?

MR LORENZONI Thank you for your question, it is a similar trend we observed for the economy at large, so if you look outside the number for GDP price level, you see a drop in 2013 which means something happened in South Africa.

DRS VAN GENT But what happened? We don't remember?

MR LORENZONI Consumer price levels are basically purchasing power parities the ratio to exchange rates.

DRS VAN GENT I know, but a 10% drop in one year against twenty OECD countries. It raises questions doesn't it?

MR LORENZONI It could raise questions, but I mean I can tell you that all the numbers that we got, were validated and I am not surprised by this

drop particularly in South Africa, because it is a drop in the economy on the hospital side. It is something we observed and I think it is very much linked to the exchange rate the Rand exchange rate against other currencies in particular US Dollar, so I am not surprised.

DRS VAN GENT I am because I am here in South Africa since 2014 and before my coming here, the Rand had a gradual dropping in the exchange rate, but not as dramatic as it has been the last couple of months and certainly not as dramatic to explain a 10% per year drop against the OECD average, so I would still like you to and I know you have much better figures than I have to look into that and try to explain that.

MR LORENZONI Sure.

DRS VAN GENT Just one slight remark…

JUSTICE NGCOBO Are we concluding on this point?

MR LORENZONI I mean I said sure, I will provide.

DRS VAN GENT Are you coming back on this.

MR LORENZONI Yes sure.

DRS VAN GENT Thank you very much. Just an annoying little thing, because I happen to come from Holland and I see your table Figure 1, where you compare private healthcare coverage over a large number of countries. I know that private health insurance accounts for almost 100% of the population, not [indistinct 1:04] but I think that Francesca and Sarah put it right, it is voluntary private health insurance here and also the table should then state voluntary price and during the presentation, I see that is mixed up some of the time. The mixing up on the left hand side of the table and not mixing up on the right hand side of the table.

One other question and that is a figure that you presented Luca where you compare income [indistinct 1:05] to the regression income to price levels. Is there any chance that we can see that draft again? Is that figure in your submission? I can't find it in your submission?

MS BARBER We actually submitted with the presentation, a separate brief where we have that graph and we have the explanation for that graph.

JUSTICE NGCOBO Can you draw our attention where that is Mam, is it

part of the submissions? There is a document here which runs to about sixty six pages, is that the document you are referring to?

MS BARBER No it is not Sir. We have a statement in the document that does refer to this analysis. However it is not in that original report. We circulated yesterday a separate briefing which includes the figure and the explanation, so we submitted this yesterday with the presentation.

JUSTICE NGCOBO So does that mean an extract from a document that is not before us?

MS BARBER We did submit this yesterday Sir.

ADV PILLAY SC Chairperson the Technical Team is in possession of the briefing.

JUSTICE NGCOBO Well could you please make those available to us?

ADV PILLAY SC We will do so yes.

JUSTICE NGCOBO Is it possible to have it now?

DRS VAN GENT We look at this very interesting graph and in Francesca's main introduction, we highlighted the blue dot that is shining

through just behind the red dot. In an early discussion, we discussed that South Africa is obviously out of the almost perfect fit to the left and quite dramatically to the left.

My question if you look at this, doesn't this picture actually represent the genie index, the enormous genie index, the inequality in South Africa and we would just look at the 10th and the 9th, we take them together which approximately accounts for all the people that are covered by medical schemes at 17% and a number of people that pay out of pocket. If we take these two [indistinct 1:09] together, would the private healthcare sector sort of almost fit in the price strength compared to the income levels of these top 20% people?

MR LORENZONI Thank you for the question, we do not have the distribution of numbers, so people who are part of the medical schemes by income design, so for sure, I respect also by looking at the percentage of expenditure which goes to private health insurance plans from the income and economic household survey in South Africa [1:10:40 – 1:10:48 – no audio] to this side 9 and this side 10, because I see from the household survey that around 8% of total expenditure by household is on health insurance plan, so

this suggests that most likely I will find members of the medical schemes in those sides, which means that mostly likely, your reasoning could be correct, but I do need additional information to tell me where the 16% of the population actually sits.

I guess they sit in these 2 sides which means that if you somehow average up even if visually they would be in the middle, but anyhow we could somehow get closer to the regression that we observed across comparative countries.

MS BARBER When we were first investigating this, we did find a report from CMS that said that medical scheme members fall within docile 6, 7, 8, 9 and 10, so this was the basis of our analysis, thank you.

DR NKONKI Thank you very much for an interesting presentation, my first question is around methodology. You described that the data represents about 60% of medical scheme members. I would like you to just explain briefly which medical schemes were excluded and what were the reasons for exclusion and whether the sample you ended up with is representative of the medical schemes population?

MR ROUBAR This was a voluntary process where we have

circulated a letter to the medical schemes asking them to share the data with WHO to calculate the results and we have collected the data for 60% of the beneficiaries in 2013, so we think that it is representative because it is quite a big number of members and also the volume of cases covered in this study also makes it quite robust.

The schemes and those who wanted to be acknowledged are acknowledged, but part of the agreement was that this will not be shared, the individual label information will not be shared because of the confidentiality of the data, but we would urge you, if you are interested, to get more deeper insight into the questions, the methodology has been tested, verified and we know that it is possible to use it and the medical schemes or administrators can use it and apply it to their data and the methodology is available there and we are happy to support you well in collecting the more detailed information.

MS NKONKI Thank you my second question builds on the point raised by the Judge earlier on, on the comparison with the CPI. I would like to know if someone were to put to you whether the issue is not so much a comparison with the CPI, but whether the prices are driven by the increases in input costs and demand and supply factors and anti-competitive practices that

may be occurring, I would like to hear what your comment is on that?

MR LORENZONI For sure, the inflation is measured by consumer price index and it could tell us more about the movement in the prices over time and again, we are aware that health is only a small share into the total consumer price index basket and so, we just follow the suggestion from the Council for Medical Schemes to just look at affordability through increases in wages as I said before, so this is not to say that we would suggest using consumer price index as a measure of changing in the price structure over time in South Africa.

It is just a reference point which specifically was used because of the statement by the Council for Medical Schemes, which relates to affordability.

JUSTICE NGCOBO It has just been drawn to my attention that there may be a flight problem this evening, you have a flight to catch, is that right?

MS BARBER Yes Sir I think 3 members of the team have to leave at 4:30 thank you.

JUSTICE NGCOBO So if it comes to that point when you think that you

may have overstayed your limit, please do raise a hand and then we will deal with that thank you.

PROF FONN One of the issues that many of the stakeholders have put forward in their submissions is that a lot of what drives costs in the private healthcare sector is purchasing equipment that they have to buy in Dollars and that the Rand Dollar exchange has a significant impact on their costs. In relation to that, should I understand that by using a purchasing price parity methodology that you have dealt with this and can you explain to me how, so that I am aware of how that works? That is my one question.

I wanted you to explain also the change in the number of cases per thousand that you presented and how you come to the conclusion that it is not related to increased numbers, so how you come to the conclusion that this is potentially driven by supplier induced demand or I suppose also it could be requests from people to, it could be either way, but if you can just go through that a little bit more slowly so that I get that?

Sorry and I have one last question and that is in relation to your first or second slide, which is the proportion of population that is covered by health insurance, so you singled out Australia and Ireland was the other that they

cover a huge proportion of the population for much less investment. My question is do they cover that proportion of the population for all their healthcare needs, or for only some of the healthcare needs, so it is duplicates, but are they using only the private sector. So in South Africa they would only be using the private sector, is that the same for the others?

MR LORENZONI Thank you I will start and then I think I will give the floor to my colleagues. This important point that we discussed with medical schemes, when we presented preliminary results, is the one relating to equipment and so a similar reasoning we heard from medical schemes. The only way to answer that question is through collective detailed information as to equipment, so which share of the total price that medical schemes reported to us, could be accounted for by equipment.

On the other hand, all countries that we brought to the OECD include equipment costs into the price they provided us with and so, we assess that all the costs items which should relate to the full cost of providing those services are included into the price that the comparative countries reported.

But as I said, for South Africa in particular, it is our objective possibly to go into the tail and drill down at equipment level, but also pharmaceuticals could

be another component that we would like to study, so as to confirm that this could be a driver of the increase in prices that we observed over the 2 years, so it is an important point, but we need additional data from medical schemes to look into that.

What I can tell you, is that all countries reported also prices related to equipment, pharmaceutical, medical devices into the figure that they provided the OECD with.

PROF FONN I get that, my question is does your methodology get rid of the problem of the Rand Dollar exchange?

MR LORENZONI It does. As I said before, basically on the one hand, through price comparison item by item, we estimate purchasing parities, then we convert into comparative price level by simply dividing by the exchange rate for each country to a common currency which is usually US Dollars. We take into account the exchange rate in our comparison.

MS COLUMBO I will deal with these questions. So what happened in countries like Australia, the duplicate system offers precisely coverage for the same services which are in the public system. However, the more similar

level of prices across the systems, so that is why you have a much smaller share of total health expenditure which is accounted for by private health insurance.

In addition, what happens in countries like Ireland and Australia and even New Zealand, is that for some of the very life threatening conditions, some of the most complex like transplants or brain surgery and things like that, preference for people to go to the public sector, so even if they could have it for the private health insurance coverage, they do just prefer, they have better trust into what they get through the public sector and it is because obviously that is where a lot of the very complex procedures are done.

DR BHENGU I would just like some further information regarding the study itself. Your document on Paragraph 26, the exact reading here, is that hospital data was provided by several large medical schemes in South Africa and on Page 37, the first paragraph of the discussion session, the second sentence reads the study uses data from 625 000 cases among beneficiaries of a medical scheme. So which one is it?

MS BARBER Sorry which page is that?

DR BHENGU Here it is Paragraph 65 under discussion second sentence.

MS BARBER Paragraph 65 is incorrect, it should be beneficiaries amongst several medical schemes in South Africa.

DR BHENGU Okay I still would be more comfortable to know which schemes you are talking about? Is it schemes administered by the same administrator? I did get that there is a confidentiality issue that you referred to. I am just saying I would like to get comfort to that.

Now the subjects of the study, did they get an opportunity to critique your document and the methodology used and what were the key issues that they raised? Were there any major objections from the study, from the hospitals in particular? I am now talking about hospitals as the subjects of this exercise? Did they get an opportunity to critique the study itself and if they did, what points did they raise, whether for or against?

MR LORENZONI Thank you for the question, we collected data from medical schemes and medical schemes were our counterpart in the discussion of preliminary results, so we did not have the opportunity to talk to hospitals

directly because the data collection went through the medical schemes. Medical schemes were I would say quite comfortable with the results, the preliminary results we presented them with and the major points they raised, were in relation to whether the hospital services included in this study, were representative for the South African specific service provision.

The other point related to equipment pharmaceutical, so whether we could eventually take into account changes in prices of acquisition of those goods as just discussed following a question from the panel and also, somehow the other question, the other discussion was very much focused around benchmarks, so the set of countries we compared South Africa with and this is why we also added a second benchmark which relates to low income OECD countries, so as to offer 2 different viewpoints about the same subject, but as I say unfortunately, we had no chance to share preliminary results with hospitals because as Tomas said, we invited medical schemes to participate in this study, so it was a formal letter of invitation from the OECD and WHO to medical schemes and then on a voluntary basis they provided us with the data.

DR BHENGU No I think Judge for your consideration, I think there would be a case to consider maybe where later on in the other public

hearings, maybe the opportunity for us to get to hear where also the subjects get a chance to interrogate the methodology for example and maybe that will be when we look at the dynamics of the industry, if only to help us because we are obviously making a strong case, but I suspect maybe they would like to get to the bottom of this.

Now on the one case, where you make points about private sector affecting public sector operation as well, one of the issues is of course the medical practitioners, what they get paid affects the public sector. Now there is almost an opposite effect in line with the occupational specific dispensation where the submission hospitals keep saying the high levels of pay for nurses affects how hospitals are able to attract nurses. I am just seeing that as almost 2 sides of the same coin and I would like to know whether that reverse does come into affecting what your study shows, but at some point, if not today, but I thought that would have been the next sentence, because it almost addresses the same thing where the wages of the one affects the structure of the other sector.

Then the last one is about the very first slide, this one, the graph. What message, I just want to be sure that the message you wanted to convey

through the slide I got, what message were you trying to send here?

MS COLUMBO Let me answer this one. The main message here is just the share sides of the better health insurance market and we know that the health insurance market is the main payer for private hospitals and private services. So here what you see, is that it is huge, it is like 40% of total health expenditure, it is even higher than what you find in countries which traditionally large markets like the United States, also Chile or even France which is a large market.

It serves a relatively smaller share of the population we are talking about 16% of the population which is somehow contrast with other countries in the OECD which have a similar duplicate role for private insurance. It is just a point to the very large share of the market and a large amount of spending is devoted to a relatively small share of the population.

DR BHENGU But is it always a fair comparison? A lot of the countries here, have got a model that we don't have, which is almost the private healthcare sort of prepaid. We are obviously working towards that in terms of universal health care, but isn't this a little bit dramatic given that we are not there yet? The fact that the next one which is the US, is the one that

comes closest to our private sector. Is that not the case? That is the one question.

The other question is, is it really also not, can one also not interpret it in that way that is it a question of those with medical schemes opting to use the private sector, maybe because the public sector is not so competitive. Is that a way of reading that graph?

MS BARBER This particular graph focuses on OECD countries because this was the point of comparison in the document. However WHO does collect national health accounts data on about 120 or 130 countries and the graph looks very similar. South Africa spends a higher share of its general health expenditure on private voluntary health insurance than any other country in the world. In the graph and I can certainly submit this and show this to you, in the graph we see South Africa, but we also see Botswana and Namibia towards the higher end, so this does suggest there is a structure of the private healthcare market in these countries perhaps related to the architecture of the healthcare system in the Southern African region and so this is an issue that we propose to discuss in Set 6, the regulatory sector, because we would like to illustrate how unique the Southern African region

is, because of its history, because of the history of inequalities, because of the history and the development of the healthcare system architecture thank you.

DR BHENGU My question was going to the context because that context is important as a discussion separate from the price.

MS COLUMBO On the other point that you raised, I would like to respond by looking at the issues of how countries are trying to achieve universal health coverage and therefore coverage for the entire population and it is true that what you want to have, is to make sure that there are quality of healthcare services built in in a very systematic and standardized ways across all of the countries. In some OECD countries, people sometimes say I want to go to the private sector because they have a better quality. In reality, what they judge by quality, is the possibility to have a private room or to have better amenities.

It is quite clear that once you engage into a very important and difficult reform process to achieve coverage for an entire population, you also want to make sure that the standard of qualities are the same across the system.

MR ROUBAR Can I just add for the hospitals component, so as you

saw for all the other countries studied under the OECD project, they don't have this cost component built into the price, so we tried to make this effort to make this extra step to see when we have the total price, what is the cost component within it and we found out for the first time what are the cost components and I think now that when we know the hospital component is 50% or 60%, we should understand this, what share of this goes to like labor, capital and these kinds of things.

Like Luca said, the methodology didn't allow us, because we were assessing the data through medical schemes, so I think the next step is really trying to understand what is happening there within each of these cost components, but we were also somehow limited by the data which was given to us.

JUSTICE NGCOBO What is the status of this report?

MS COLUMBO It has been released as a health working paper.

JUSTICE NGCOBO It is published is it?

MS COLUMBO Yes it is published.

JUSTICE NGCOBO On your website?

MS COLUMBO On the OECD website and on the WHO website.

JUSTICE NGCOBO So everyone who wants to have a look at it, would have had the opportunity to do so?

MS COLUMBO Yes please do, even give us comments or suggestions.

JUSTICE NGCOBO When was it published?

MS COLUMBO Today.

JUSTICE NGCOBO Not before then? Okay, so it is just fresh from the press.

MS COLUMBO Yes.

JUSTICE NGCOBO Okay I understand. I take it that from today onwards the stakeholders who have not had the opportunity to consider your finding, will now have that opportunity is that right? Yes okay very well. Now in the course of your investigation and I am mindful of the time, did you have occasion to consider what might be the factors that have increased volume and intensity in the private health sector?

MR LORENZONI Thank you very much I think this is a key point also for the way forward, because what we look at, is the price component. What we would like to look at, is the volume components. To do so, we will need data on hospital expenditure, because at the end of the day, what we would like to know is that only hospital price level, but also hospital volumes per capita, so to compare cross countries also the volume of services provided by hospitals and to do, we need hospital expenditure data, so as to use comparative price level as a deflator to standardize for price changes over time and what is left out, is the volume which is the most important part of the story, because it relates to services provided by hospital to citizens.

In the pipeline if I may say so, it is also the intention to look at the volume components which will tell us more about whether this is a utilization issue, which relates also to the intensity of service provided during the hospital stay and concerning intensity, we selected this representative list of hospital services on the basis of international compatibility, so they are standard service provided by hospitals across all countries, OECD member countries, which means from Japan to Mexico and down to Italy, so that is our purpose, but again, what we would like to work on, is this volume component and if I may say that, the public hospital component, because it would also inform our

study, learning where does the public hospital sit in this comparison because in our chart, we just plotted private hospital service levels against GDP per capita.

We would like to include another point in the chart which says where does the public hospital component sit in that chart, so that we could have an exhaustive picture of what is going on in this country in an international context, so I think this is the next step if I may say so, which is quite challenging.

JUSTICE NGCOBO And when are we likely to commence that next step and do we know when it is likely to be finished?

MR LORENZONI I can tell you that the WHO country office in South Africa is working on producing national accounts so we would most likely have data on hospital expenditure and maybe Tomas could also tell you when, while we are currently working on collecting data from public hospitals. I can't tell you when sorry, but it is in our current work plan, because I think we also need to inform the Commission what is going on with public hospitals.

JUSTICE NGCOBO I think I would be grateful to know when you deal with matters of increased volume and intensity what impact if any, do conditions in the public sector have on the volume of work on the private sector, because we have been told by some of the submissions that the deterioration in the services offered by the public hospitals has increased the demand for private hospital services. I would be interested to know the validity of that statement.

MR LORENZONI I think it would be our pleasure to share with you some findings of this eventual shift from public towards private, but it goes back to another point that Sarah mentioned in her presentation where we should also look at quality. We didn't do so in our studies, so if I can add a third component for our future work, this will equate to quality, because it goes in the direction of answering your question. What we observe is a shift from public hospitals towards private hospitals because of quality issue. I would like to answer that question, but to do so, I need additional information that today is not available unfortunately.

JUSTICE NGCOBO Thank you for your presentation, before I release you,

are there any remarks that you want to make before you leave?

MS BARBER In this particular report, we didn't come up with any specific recommendations, but we are looking at this for future submissions, but we could emphasize one aspect that we observed throughout the last couple of days during the presentations of the critical issue from our perspective is really determining the role of the private healthcare sector as part of the national health system within the context of South Africa, but both WHO and OECD have made commitments and support countries globally under the international commitments that you mentioned in your opening statement to achieve universal health coverage.

In South Africa, the Government and the Honorable Minister has put forward a laudable plan for national health insurance which is essentially the roadmap for universal health coverage and I think NHI essentially provides this framework and a common commitment for universal access to quality healthcare under which we can determine how the private sector fits.

What I have observed is that there does seem to be efforts to try to fix the problems in the private sector, but I think it is quite important to ensure that these efforts are in line with the overall goal that we would like to achieve

over the longer term and once this framework is in place, as we have said before, the private sector could be contracted to deliver services to specific services to cover a wider geographic region or essentially provide complimentary coverage, but I think what we are also pointing to, is that to be able to do that, you do need a price schedule.

I think there was a discussion about price setting. However the process of a price schedule is a technical exercise. It is a matter of coming together with a specific methodology where everyone agrees on that methodology and you have technically sound prices, thank you Sir.

JUSTICE NGCOBO Thank you.

MS COLUMBO I think what I would like to add is to re-emphasize the issue of quality. From the experience of OECD countries, there are some important learning that comes out in the efforts like the history of achieving this universal health coverage and we think that some of the lessons from those countries are critically important for a country like South Africa. It is important to build quality from the start.

The other critical thing that OECD countries didn't get it right from the start,

is that there was a huge emphasis on making sure that there were enough hospitals, there were acute care facilities and not forgetting the huge fundamental role of primary healthcare of community care. Not only OECD countries, but all countries are affected by growing chronic conditions. We heard some of the people earlier on.

JUSTICE NGCOBO Well thank you once again for that informative presentation and thank you for making time to come to this country to share with us the product of your studies and your research and we are looking forward to the next step and its conclusion and I can only express the hope that if it could be completed before August I would imagine, because we have a limited life, so it should be able to come before our term of office runs out, thank you.

Dr Mabasa I understand you have been very patient indeed. I hope you are still here. Dr Mabasa, thank you, for your extraordinary patience.

DR MABASA Thank you Chairperson and the esteemed members of the committee. I tend to have a very bad habit in that it is very difficult for me not to acknowledge that the Minister is here, so I also have to acknowledge him.

Chairperson I came here more as a member of the public. I derive my experience in being able to talk today simply because I am a citizen of the country. My experience also derives from the fact that I have been a patient as well. The way that I have structured this, it is more to put the skeleton to the flesh that was put by the WHO. It is interested that we are finishing with the bone and they gave the meat.

It is well known that our healthcare has been said to be hospicentric and as a result, it is no wonder the highest cost of healthcare service is at hospital level as confirmed by the Council for Medical Schemes report, so you may have seen this report many times and the graph who tells you who is the highest, who comes next. Just for me not to take too much of your time, I will refresh your mind, I will tell you that first is the hospitals at about 35% to 37% and then specialists at about 23%.

Having said that, the fact that specialists come in second, should not come as a surprise and should not imply that they are over charging, as they are expected to be the ones consulting and treating patients at private hospital level, so you will imagine that if people are at the hospital, their only point of call is the specialist and all the other people are related to them and as such, it

is therefore not surprising that they should get corresponding income. I wanted to clear that because people may think that specialists are earning more because they are charging more. It is not just about that. It is when people are admitted as we have heard they have to be seen by a specialist.

The fact that GP's, I am a general practitioner let me declare Chairperson and only 6% to 7% should be seen as a sign of an anomaly of our primary healthcare. GP services has been curtailed to an extent that patients have to visit the hospital and be seen by a specialist more often than they should, as GP's are restricted from seeing patients as benefits get exhausted as early as April.

By the end of April, patients do not have benefits and a GP who sees a patient who is on medical aid, is very sure that that patient will be treated because there are hospital benefits, therefore we refer for admission unnecessarily and we need to do that, if you have to treat a patient who has got a medical aid, hospital benefits are still there, then you have to refer to the hospital, because the hospital benefits are there and the specialist must see that patient, that corroborates that.

Prior to 2004…

JUSTICE NGCOBO Can I just ask you a question. Are you suggesting that even in circumstances where it is entirely unnecessary to refer a patient to hospital, the patient will be referred to hospital for the sole reason that you have advanced?

MR MABASA Exactly, before 2004 medical schemes, hospitals and medical practitioners as well as other providers, used to sit around the table and debate a reasonable tariff. That standardized the tariff and brought about certainty. That fee would be debated by the schemes who should be protecting their interests, the providers will be protecting their interests, including the hospital, so there were checks and balances in the schemes that wouldn't like to be ripped off in that discussion, neither would the profession but what comes out is a consensus that came about, so this brought about tariff certainty, so if you removed the appendix, it was the same price at Malamulele and in Cape Town.

Now it is no longer the same. Then the Competition Commission was introduced to say don't charge this same price at Malamulele and in Cape Town and I tell you how it happened. The issue that happened was the Competition Commission said that patients should compete for the cheapest

doctor, so to illustrate my point, if a doctor did an appendectomy and one would say charge R20 000, another one says I am charging R3000, the patient had to shop around with an acute appendix. By the way, that condition can lead to a bursting of an appendix, so that was said to be controlling the prices because it was competitive.

In other words, what was competing here, was the doctors but the patient has to choose the one who has offered the least, it was like an auction. Now that is deemed to be competitive and I must say that was the first time we had problems in this country. If you compare the time before 2004 after this was introduced and you compare it with the time after that, prices ran amok and I don't blame the authorities.

The scenario that I have, it cannot apply to a patient who has just sustained multiple fractures from a motor vehicle accident who needs a doctor immediately. That one doesn't have time to shop he is at the mercy of the doctor that he meets first, whether it is a 5 star doctor or a normal doctor who charges a normal fee. So we are at that mercy and that competition is so unfair for this patient who is so useless and helpless. You will see in the recommendations as to why I want this to be sorted out as a representative of

the public and also a recipient of healthcare and also a medical practitioner.

The person is at the mercy of whoever treats him, whatever the price that is if you are coming from an MVA. Therein lies the problem with this ruling by the Competition Commission. The patients become victims of the price. No standards, no checks and balances, it is free for all, except for the patient. For the patient, it is not free. Patients are victims of the price havoc.

After this ruling, the following happened. The ruling happened in 2004. The medical practitioners have no limit as to what they can charge. The medical schemes pay different rates for similar services as well, so the medical schemes also got into the fray, they are also dancing in that pool. If you belong to Discovery, they will give you a certain amount. If you belong to Bonnitas, they will pay a certain amount and what then happens, is that the doctor being the same, if he charged Discovery R10 000 and they pay him, he charges a Bonnitas member R10 000 and they pay R2000, then the patient remains the victim in that he has to pay R8000.

I had a patient myself Chairperson who had a dental problem and went to a dentist as an emergency on a Friday afternoon at 6:00 pm. They put that patient to sleep, I am talking about my own patient, she was earning R2000 as

a helper in a household then somehow she had a medical aid because they then saw her and treated her. After 2 months, a letter came, she was owing R11 000 at a very reputable hospital next to where I work. The reason being the medical aid declined because they didn't pre-authorize and it was an emergency, so I then phoned the CEO and requested that that be written off because this one earns R2000, she will never miraculously raise R11 000 in her lifetime to pay. After a few hours, he phoned me to say it is written off.

Now patients are not aware of this new empowerment, because it is an empowerment to shop around. What the Competition Commission did, was to empower patients to shop around. When they are sick, they just want to be seen and be treated and healed, they don't want to go around looking for a doctor who is cheaper. Some may be so sick, that they are unable to shop around the country for the cheapest doctor, so this ruling came up with that.

MR SELEKA But how do you reconcile the empowerment aspects with a patient not having time to shop around?

MR MABASE I am saying the empowerment is that they should shop around, but a person in a coma, cannot use that empowerment she is at the mercy of the doctor. He is disempowered in that whoever meets may be the

most expensive, so that is what I meant by that. It had a fact of sarcasm in it, but it also had a fact of reality.

Now let us look at what has happened about hospitalization. We have now heard that hospitals are expensive, specialists are expensive. Now let us look at why. Erosion of primary healthcare, no wonder our healthcare is hospicentric, it is hospicentric and consequently, expensive with no standard and guidelines. I am happy that the previous presenters talked about lack of benchmarks.

GP's can see many patients and render very cost effective services at primary level if they were allocated enough budgets to avoid unnecessary referrals. The scenario at the moment is that medical schemes have eroded services that can be rendered by a GP, ending up having such conditions referred to hospital.

Any exhaustion of medical aids for example, sometimes as early as April, when a patient comes with a follicular tonsillitis which I could give antibiotics for, you end up referring to an ENT specialist because by the time he comes to you, he has no benefits, but you know he has hospital benefits. He will then be admitted by an ENT specialist and he will then be admitted at

the hospital and they must charge legally. Of course they are rendering a service, but was he supposed to be there? No.

A sty, which is a small abscess on the eyelid, we end up referring to an ophthalmologist once benefits are exhausted and we do it very courageously because then we know they will be admitted and be treated for something that he would have paid me R500 for, you end up paying R5000.

A skin wart which you just excise and go and test to see what kind of lesion it is, you end up referring to a dermatologist or a general surgeon and that person will then be seen by a general surgeon and be admitted at the hospital and by the way, when we realize and I am saying what we do and I do it every time, when we realize that they need appointments and they may not be admitted or they may not be seen and it is an acute situation, you book for admission because that is the only time a specialist will come when he is doing rounds to see that patient. That is the anomaly of our healthcare system.

Do you then still wonder why patients go to the hospital? GP's are now forced not to do what they could do. Rural areas are GP populated. There are no specialists. GP's are doing a lot of work including cesarean sections, they

are doing laparotomy's, they are even doing hysterectomy's but because the medical aids have now started to say in the urban areas, the GP's must now be skilled in a particular way.

The reality is that the GP's do it once they are more confident and they have more experience in the procedure, so the intention is not to murder a patient, so what happens then is if you don't know how to do it, never touch it. That is the principle. If you know how to do it, do it confidently and be paid for it. So that is how GP's should function.

Influenza, you end up sending the person to the hospital as pneumonia. So I am saying give more primary healthcare benefits so that you reduce the cost by anything up to 30% to 40% because people won't be admitted unnecessarily. They won't be sent to the specialist unnecessarily. They will go only when they must and a GP knows when they should. If you encourage referrals to hospital, the status quo will remain and that is how our medical aids are running.

Our conundrum arises from one a lack of central structure to regulate fees in the private health sector. The second one it is lack of coordination in the laws that govern private healthcare. 2 or 3 weeks ago, the health professions

council issued an advert that said the patients must ask for pre-authorization themselves and then [Gogo Khumalo] cannot phone the medical aid and pre-authorize. The health professions council says it is the responsibility of [Gogo Khumalo] not the doctor, to pre-authorize because doctors are taking too much on the phone arguing with the medical aid.

This is the disease that we have. On the other hand, the medical aid schemes have got a liberty of drafting rules to say you must as a doctor, pre-authorize and the health professions council says no, it is not your responsibility, the patients must do this themselves. How would they know the ICD10 codes of this when eve the doctor is confused?

There is a plethora of regulations from multiple medical schemes which at times become more of a burden than disease itself. I referred a patient who was sixteen weeks pregnant to a radiologist for a, sonar. Another body, an insurance company, has issued a rule that no one must now, do a, sonar beyond twelve weeks, the rule exists. Now that means the issue of assessing patients has now been compromised, because if it were me, I would do a sonar every 4 weeks to see whether this baby is growing or has died already, because if you stop at twelve weeks, how will you know whether that baby is

still alive or not.

But there is a rule by an insurance company which has stopped radiologists from doing it. The schemes don't want GP's to do ultrasounds as well, which they can do and just get the basics of what the fetus looks like and these rules are coming because our healthcare environment is over regulated, miss-regulated and there is havoc of regulation and that must be cured.

Poor communities are being disadvantaged by their own schemes, because they are expected to know the rules and these rules are written somewhere and put on the website. Many people don't even have a computer.

There appears to be a need to establishment a sub-directorate within the Department of Health. This sub-directorate will be dedicated to private healthcare that would exist beyond this task team. For me, we need a dedicated sub-directorate. The composition of that sub-directorate should be comprised of representatives of relevant stakeholders who are experienced in that field, so that at the end, whatever comes out of that, advises the Minister correctly.

The general practitioner consultations should be treated as a PMB. No one

must be sent to a specialist when they are sick and can be treated by a GP and no GP must not, be paid when they have rendered the same service. There is a need to relax and expand the scope of general practitioners without making it an onerous exercise.

We used to do x-rays. The Department of Health issued a restriction to stop GP's from doing x-rays. Now I have to send the patient to the hospital and the patient has to look for transport. The ruling of the Competition Commission needs to be repealed, that is a recommendation. It should be repealed to allow for discussion on tariffs that will be regulated, agreed upon and controlled so that it is standardized.

This sub-directorate should also be assigned a duty to study and cure defects in the medical schemes act, health professions act, national health act and all other related laws governing private healthcare with their corresponding rules and regulations.

If you do this, you will cure the situation of price uncertainty and blaming people who have charged legally.

JUSTICE NGCOBO Thank you Dr Mabasa. Are there any questions?

ADV PILLAY SC Dr Mabasa, thank you for your useful and robust presentation. The first issue we have is just coming to terms with some of your recommendations and the first one which we would like to deal with is a recommendation to in your submission and I think in part you have answered some of the dilemma and that was trying to locate that recommendation within the current model for PMB's, which as you know is based on diagnostic and treatment pairs and I was just trying to understand how it is we would fit a consultation of the GP in within that scheme, but as I understand from what you have said now in the course of your oral presentation, is that what you are really looking at, is that really there are 2 parts to it.

The first is a legislative enactment which compels members of the public to seek assistance or consult a primary healthcare provider before they refer to a specialist and secondly, finding a mechanism to ensure that schemes fund such a consultation even when benefits have been exhausted. Am I correct, that is what you mean?

DR MABASA Agreed.

ADV PILLAY SC Then just in relation to recommendation 3, we just want to understand what it is when you referring to expansion of the scope of

practice for general practitioners, from what it is now and how do you want it to be expanded?

DR MABASA The fact that we have been stopped from being allowed to do x-rays, nowadays there are very nice mobile x-rays. It is reducing the scope of practice of general practitioners, because that was helpful. A rate for a GP if he does an x-ray is lower. Secondly, there was an issue of the fact that we can't do sonars and nowadays, you find that a lot of the things they say we need certificates for. One of them was dispensing. It was reducing the scope of a GP to stop him from dispensing.

I am trying to say let us look at what can be done. We are not rigid on what we want to do, but we are indeed willing to do more than what we are being allowed to do at the moment.

There is a colleague of mine who was doing x-rays and he was paid for a number of years and I will mention the scheme here from Medscheme. They took all his money R600 000 that they paid over the years for x-rays that he did when he was licensed to have an x-ray. They took R600 000 back, because they said for all those years, he didn't have a certificate for it. These are the injustices that we are facing.

DR BHENGU On the issue of the declining share of the general practitioner and the healthcare rand, you say it is about 6% or 7%, but would you not say that general practitioners are to a certain extent their own worst enemies here. The example you used of course first prize would be to treat a primary care condition in your rooms, example of tonsillitis, even when you feel that you want that patient admitted, what compels you to refer to a specialist and not admit and treat the tonsillitis yourself in hospital?

DR MABASA I did explain the reason is that from April, there are no more benefits for a GP in the main from April downwards. When they still have benefits, we treat them very well. The very person we treated in January, when he comes in June, the medical aid can't pay you, there are no benefits, because the benefit for GP's are so low, that is now hospicentric in the real sense of the word.

DR BHENGU Okay I think that is an important point that I was missing. Are you saying there wouldn't be benefits for a general practitioner, not that there are no benefits for out of hospital treatment, because that is different?

DR MABASA There are no benefits for out of hospital. When they get finished, even for specialists they don't pay, so what we do, we make a plan so that the patients get treated. We just refer for admission.

DR BHENGU No but are you saying the benefits when they get exhausted, for any GP intervention whether in or outside of hospital, because my question is how many of your patients that you see, how many admissions in hospital are you doing as a GP for example?

DR MABASA Some hospitals are very far from GP practices if I were to put it that way, so if you admit on your own, it would have been a good thing, but you see you have to travel some 10 kilometers and now you are leaving your practice, so there are complications related to that. I think the solution shouldn't even be for a GP to admit, but it should be for the benefits to be available so that the person can be treated.

PROF FONN Dr Mabasa do general practitioners have admitting rights? Is there anything that stops general practitioners admitting?

DR MABASA Not at all.

MS MUVANGUA Dr Mabasa it was spoken earlier here about accessibility of private healthcare in rural areas. What is your general take on having a requirement for a certificate of need?

DR MABASA A certificate of need I don't think in principle people had a problem, but the principle that was there, was the threat to what it might imply and that is what needs to be worked on. I will give you an example of an intervention I made in the Eastern Cape and Mpumalanga. There was a young doctor who phoned me, she is married to a doctor in Mpumalanga and she has got a bursary in Eastern Cape. I had to talk to the Superintendent General in the Eastern Cape to allow her to be released to Mpumalanga, so the certificate, which she agreed, the thing about the certificate of need, is whether it will imply that if I am working in [Kwamvanga] you might remove me and relocate me to Mafikeng, so these are the things, but it can be worked on. If it is hurried, it may be mal-implemented, but if it is done quite well and methodically, it might end up being the decision that we need.

JUSTICE NGCOBO Dr Mabasa you make the point in your submission about the rural areas being serviced mostly by GP's. Now in your experience, what can be done to enhance access to healthcare services in the rural areas?

My limited experience of some of the rural areas is that your nearest doctor or healthcare service will be provided by a GP. The hospital will be further away. The GP will be located in the nearest town which is accessible by foot, taxi and so on. Your hospital services will be further away, but how does one increase access for those individuals who are there?

DR MABASA The market as it is now, is such that many people who are GP's in the rural areas rely on cash because medical aids are not many, but the issue is that even the training itself, is improving with the increasing training that we have where the Department has a plan to take people from provinces. The [indistinct 2:32] to it, should be that people should work in that province for a certain number of years and if that is continuous, you will be able to improve access because what then happens is you've got people who are trained and funded by a province and therefore they have to serve that province and when they become GP's, they will be GP's within that area.

In that very province, those that have trained there, the need becomes a provincial issue where you say I will license a new practice so if you want a new practice you apply with us, but we shall give you that area.

I really hope that the national health insurance will happen, because that will ensure that even when you are in a rural area, you are assured of being paid for seeing patients, not waiting there for people to get cash here and there. I think national health insurance if it well implemented, it will definitely be part of the solution to the problem because it will address the funding dilemma that a rural practice experiences. Running a practice is very expensive as well.

In the past during the homeland system, there was a bursary system that if you are funded by this homeland you must go and serve there. Some of the good things out of the bad system need not be discarded.

JUSTICE NGCOBO Earlier today, we were told about poverty in the rural areas and unemployment. Now the health services from what you are saying, in these areas are provided mostly by GP's. People have to pay when they go there. Now where do they get the money to pay for these services? They don't have medical aid we were told, some of them.

DR MABASA I will give you an example of a friend I have. He makes R6000 in cash per day because they don't have medical aids, but it is not everybody who can afford it. People are not accessing GP's because it is

expensive to see a doctor as well and so there are those who can afford, but many cannot afford, so they rely on the public institutions.

The dire need for healthcare services in the rural areas is shared by all of us and the concern is shared by all of us and that must be addressed and we need to assist in making sure that the system works, which is why I came.

MS MUVANGUA I just have one last question. So the HPCSA allows doctors to own shares in hospitals? How do you think that impacts on referral patterns by doctors?

DR MABASA Firstly, that would be very unethical on its own if you owned a hospital and you refer to your hospital and I think that needs to be looked at, because these are the very things we are saying needs to be audited, so that there is some guideline as to what you can and can't do. It is not correct for me to have a brother who is an ENT surgeon and refer even an itchy finger to an ENT surgeon just because my brother must earn. I will regard it as perverse if you have shares in the hospital and you admit.

JUSTICE NGCOBO I just want to press this point further, but no further than this. One understands that people living in the rural areas who are

unemployed afflicted by poverty would make use of their livestock, sell them to get cash to go and see a GP, or perhaps go to a hospital. Now we do know that some of the rural areas have recently been hit by severe drought, resulting in death of many livestock. Do you know how people survive in these circumstances?

DR MABASA This is a very big challenge. What I want to say is that GP's also, have a heart. They never leave an emergency and dismiss it. As a doctor, I have 2 functions. One is to be compassionate, so therefore only those people that you think need urgent intervention without paying, you definitely should be able to help.

JUSTICE NGCOBO Thank you Dr Mabasa for that very, practical presentation that you have given us.

DR MABASA Thank you Chair for allowing me to speak as an ordinary member of the public and a layperson, especially that this is an esteemed hearing and I must say thanks to yourselves for allowing me at very short notice to come and have a word or two about this and that.

JUSTICE NGCOBO Thank you Dr Mabasa for your presentation and thank

you for making the time to come and see us.

Tomorrow we will be listening to oral presentations from the Cancer Association of South Africa, the South African Society of Cardiovascular Intervention and the Society of Private Nurse Practitioners. This is now according to the program as provided to me at the moment. We will again start at 9:30 tomorrow morning, thank you so much for your patience.

[END OF RECORDING]

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