JUSTICE NGCOBO The program for today is as follows. We will hear from the Cancer Association of South Africa who will give us a presentation from now until 10:30, followed by the South African Society of Cardiovascular Intervention who will take it from 10:30 to 11:30 and then we will take a break.

Then we will come back and listen to the presentation by the Society of Private Nurses Practitioners who will take it from 11:50 to 12:50 with a lunch-break in between until 2:00 pm and thereafter, we will listen to COSATU from 2:00 to 3:00.

I understand that Professor Herbst you are here to make a presentation on behalf of the Cancer Association of South Africa?

PROF HERBST That is correct Mr Chairperson.

JUSTICE NGCOBO Just for the record, do you want to place your name on record and who you represent?

PROF HERBST I am Professor Michael Herbst from the Cancer Association of South Africa and Mr Honorable Chairperson and members of the panel, I want to apologize that you have to listen to a second time to me. I

worked with my colleague on this submission originally, but when it became evident that I was going to bring a personal testimony here, I withdrew from the process, but unfortunately in the meantime, my colleague has been called away to Dubai to participate in a training program of health advocates and it then fell back into my lap to come and present to you today.

Mr Chairperson on behalf of the Cancer Association of South Africa, I would like to make the following presentation and submission. Cancer is part of the non-communicable group of diseases, which means that it is not contagious, it doesn't spread from person to person and as disease in itself, a complex of diseases, it requires priority intervention in South Africa, especially so Mr Chairperson we are one of the few countries in Africa that don't have a national cancer control program.

Added to that, we are still working on the 2010 cancer statistics, because the national cancer registry is way far behind in the work that they are doing in providing us with statistics. Only on 26th April 2011, did the Minister of Health following a years of advocacy by the Cancer Association, did he publish requirements that cancer will become a reportable condition, so we can only accept cancer statistics from about the year 2012 whenever we get

that register from the registry.

Now according to the 2010 national cancer registry, a total of just over 56 894 individuals were diagnosed with cancer. It makes it a very important disease, complex. Males in South Africa for the whole population have a lifetime risk of 1 in 8 to be diagnosed with cancer and women have a lifetime risk of being diagnosed with cancer a risk of 1 in 9.

Now even these statistics that I have quoted to you, are not accurate because in 2010, we still didn't get a complete picture because of the private sector especially keeping back statistics and hiding behind the excuse of confidentiality and that they cannot provide information of their clients' to anybody else, so we will have to wait until the 2012 statistics to get a clearer picture of what the situation is in South Africa.

The Cancer Association of South Africa wholeheartedly endorses the initiative that aims at reforming health care in South Africa, but we are of the opinion that the macro process cannot be allowed to prevent the continuation of prescribed minimum benefits, the review process as it was originally envisaged.

Patients have already waited far too long for the Council of Medical Schemes to fulfil its current mandate to review the prescribed minimum benefits. I am convinced Mr Chairperson that the Council for Medical Schemes will tell you yes, that they are working on it, but they have been saying this for a very long time and we believe that the time has come that we must really have a review of the process because patients are in the meantime suffering as a result of not having the benefit that they should have.

There is also terminology within the benefits document that is problematic and especially the word treatable cancer. Now as the term is explained, it means that the cancer must involve only the organ of origin. There must be no evidence of it having spread outside that organ and I am quoting have not by means of compression or other means, brought about irreversible and irreparable damage to the organ within which it originated and I close my quote.

This means that it really becomes problematic when patients are seen by their oncologists. We are aware of the fact that doctors see patients sometimes 10 times before they are referred and there are periods of time in between each visit and a new prescription is given, we will put you on this medication and

then after another week or so, another prescription and by the time that the patient sees or is referred and is seen by his or her oncologist, the disease has spread outside the organ and this immediately disqualifies them for any of the benefits that they should have been entitled to.

I would like to quote to you a statement issued by the South African Oncology Consortium in November 2007 and I quote "the term treatable cancer cannot be used a motivation to deny patients adjuvant or definitive therapy spread to draining lymph nodes cannot be interpreted as adjacent organs as lymph nodes are not considered organs. The use of adjuvant or definitive chemotherapy and radiotherapy, has had a profound effect on survival in such instances, for example anal, breast, cervical, color rectal, endometrial, gastric, head and neck nasal pharyngeal cancers" and I close the quote.

There is also no reference really made to the term cancer of unknown origin and this is a serious oversight in the documentation. Now cancer of unknown origin is becoming a very prominent incident and occurrence. According to the 2010 national cancer registry, 1 528 cases of unknown cancer were diagnosed in men and 1 465 cases of cancer of unknown origin were

diagnosed in women. In support of the statistics Mr Chairman that I have quoted, I am leaving behind with the Commission, the cancer fact sheet of the top 10 cancers per population group as well as the cancer fact sheet on cancer of unknown primary.

Oncology benefits are always or very often stated in the documentation as being unlimited. This is clearly not the case and it creates unnecessary anxiety and helplessness in already stressful situations for patients when clinically appropriate treatment is declined by the medical insurers. We have on record Mr Chairman, people who come to us and they say I have run out of any benefit, we have had to sell the second family car to try and cover costs. We have had to take out a second bond on our property to try and cover costs.

Then also the management of symptoms and the therapeutic management of pain in both adults and children diagnosed with cancer are key elements and it really requires attention in respect of prescribed minimum benefits. In support of my statement about pain control in cancer patients, I would like to leave with the Commission, the cancer fact sheet on pain control in cancer.

A few other points of interest that we would like to bring the attention of the Commission will be the consideration for oncological emergencies related to

metabolism obstruction and treatment which we believe should be included in the prescribed minimum benefits. We also believe that there should be risk-based cross subsidies as these are essential in cancer as every individual diagnosed with cancer is unique and has unique disease profile.

Medical schemes should have effective control mechanisms in place to address efficiency through risk adjustment. The Cancer Association of South Africa supports the notion that patients, to whom prescribed minimum benefits apply, must not be compromised and in truth Mr Chairperson, they already are compromised.

We also support the engagement with stakeholders by the National Department of Health to align the national health insurance and prescribed minimum benefits. However, it is subject to the legislative processes and necessitates for the prescribed minimum benefits to be adjusted to include the concerns that we have already mentioned up to now.

We also support the principles and objectives of the prescribed minimum benefits in its goal to enable equitable cost effective access to care, ensuring maximum quality of life for all cancer patients. However, we would like to see this clearly reflected in the benefit design and it should cover solid as

well as hematological tumors, palliative care and oncological emergencies, which are not always covered.

For instance Mr Chairperson, a person could be admitted, a lady patient with severe hemorrhage from the vagina and this could be as a result of bleeding with cervical cancer or cancer of the uterus and what will be of benefit to that person, is to immediately get a massive radiation process to try and stop control of the hemorrhage which isn't done because the disease is already spread outside the organ and they do not qualify for the minimum benefits.

We also believe that protocol development is essential in the control of moral hazard and cost escalation. Now the classic model of moral hazards suggests that health insurance may reduce preventive care because the insurer will pay for part of the treatment in case of disease. The Cancer Association of South Africa advocates for prevention and cancer control strategies that will significantly reduce cost in cancer care and moral hazard should then be driven by experts who are experienced and have also experience in managed care practices in oncology.

Provision should also be made for ongoing cover for diagnostic and monitoring processes. Mr Chairperson in conclusion, the majority of medical

schemes do not have a specific oncology disease management process. Patients are often stranded with depleted radiology or pathology benefits and instances occur where no benefit is allocated for nuclear medicine in the event of a patient requiring a bone scan to detect bone metastasis or the spread of the cancer into the bone structure of the body.

As far as this is concerned, the Cancer Association of South Africa recommends a comprehensive minimum allocation by means of a disease management oncology plan. Mr Chairperson I thank you for allowing me to bring this submission to the Commission.

JUSTICE NGCOBO Professor Herbst we have just been furnished with a number of documents, the first one is a fact sheet on the top 10 cancers per population group, is that part of your submission?

PROF HERBST Yes I have submitted that as a separate document.

JUSTICE NGCOBO And the next one is the fact sheet on cancer of an unknown primary?

PROF HERBST There is also information on different fact sheet that will explain cancer of unknown origin.

JUSTICE NGCOBO And then there is another one on pain control in cancer.

PROF HERBST Yes which gives the World Health Organization and other international organizations view on how pain should be controlled in cancer patients.

JUSTICE NGCOBO Because these documents have just been handed to us. Are there any issues that you would like to highlight in relation to any of these documents that have just been handed to us?

PROF HERBST Mr. Chairman thank you very much for that opportunity, the only thing that I would really like to highlight is to be sitting in my chair and also in the chair of my colleague who was going to present here today, when you have a walk-in patient with a spouse or a life partner and you have to counsel them, they have been diagnosed and they have been failed by their medical aid because they do not have access, they do not qualify, they do not get access to the minimum benefits that they are supposed to get benefit to and you've got listen to the heart rendering stories that these people tell you of the anxiety that they go through and the anger that they develop because they are not getting the treatment that they feel and

that they believe they should really be getting after having paid membership fees to a specific insurer over a period of years and now that I really need that, I do not get it and that is the main message that the Cancer Association of South Africa would like to bring to the attention of the Commission, that the prescribed minimum benefits really needs urgent review and it needs to be updated into the realities of the health burden that cancer brings to the country, thank you Mr Chairperson.

JUSTICE NGCOBO Thank you Professor Herbst.

ADV PILLAY (SC) We have a few questions Chair. Professor Herbst, thank you for the presentation, the first question that we have for you, centres on your definition of the word treatable. Now we know that the word treatable is used in Annexure A to Regulation 8 which sets out the lists of PMB's. What I am unclear about is the definition that you have reflected in your submission, what the origin of that definition is and how it is used to define the regulation or the annexure to the regulation?

PROF HERBST Thank you for that question, I am unfortunately in the unenviable position that I am presenting from a document not prepared by myself, but from reading the document that Ms [indistinct 17:35] has

prepared and the sequence that it follows, I am sure that she is quoting from the Council of Medical Schemes documentation on prescribed minimum benefits because immediately following that, it says that the term treatable is a problematic term, so I would take that it comes from a document prepared by the Council for Medical Schemes.

I know that there is somebody in the audience Dr Pillay who may be able to provide some information on this as well.

ADV PILLAY (SC) All right but the definition is not contained in Regulation 8 itself? This definition of treatable we don't find in Regulation 8 itself.

PROF HERBST Sorry I cannot confirm or deny that statement.

ADV PILLAY (SC) Now if I understand your submission is that to a large extent the cancers that are reflected in Annexure A are for treatable cancers and not the untreatable cancers?

PROF HERBST That is correct.

ADV PILLAY (SC) Now I wonder if you would just give us an idea if in fact…

JUSTICE NGCOBO You are raising your hand?

MR STEENEKAMP I can give some information on that.

JUSTICE NGCOBO And who are you?

MR STEENEKAMP I am [indistinct] Steenekamp?

JUSTICE NGCOBO I peg your pardon? Could you get next to one of the microphones please? Now just state your name Sir and also indicate what your interest is.

MR STEENEKAMP I am Boshoff Steenekamp I currently work with Momentum Health as a private…

JUSTICE NGCOBO I beg your pardon?

MR STEENEKAMP I work with Momentum Health which is Momentum Holdings and I was involved in the development of the prescribed minimum benefits and the regulations in the Medical Schemes Act.

JUSTICE NGCOBO Now as you are raising your hand, you want to speak on whose behalf?

MR STEENEKAMP I would just like to answer the question saying the treatable is defined in Annexure A just beyond the list of conditions. Defined is a condition which is limited to the current origin, it does not have impact life, this does not put pressure on other organs and it has a 5 year survival rate of more than 10% or more. There is a major problem with that definition in the sense that it does not define the modern approach to oncology treatment which is treatment intent must be either to cure, to create remission or to palliative and the limitations of that definition.

JUSTICE NGCOBO May I make a suggestion, if you want to make a presentation, you would have to speak to the evidence leaders so that you can register, so that you can have your evidence formally, so that everyone who comes here, understands what you are going to say. This is not a forum where you just stand up from the audience and make a statement. Do you understand?

MR STEENEKAMP Thank you Judge I apologize.

JUSTICE NGCOBO I understand that, but we would like to hear what you have to say, so you may want to speak to the technical team or somebody, so

that we can see whether we can accommodate you if we have time today, is that okay with you?

MR STEENEKAMP Perfectly fine and I apologize for disrupting Chairperson.

JUSTICE NGCOBO We understand. So if you could go back to your seat and then listen carefully, so that if necessary you can respond to whatever you want to respond, thank you.

ADV PILLAY (SC) Thank you Chair and thank you Mr Steenekamp. Professor Herbst if we can then deal with the role of brokers which you deal with at Page 3 of your submission and we just want to get an understanding because you mentioned that brokers may have an important role to play in the transfer of information to consumers and to patients around PMB's. Will you be able to enlighten us on currently, what role brokers play in the transfer of information and secondly, what role you would want to see them play in the transfer of information?

PROF HERBST Thank you for that question, according to my colleague, the broker services as it is defined in the Medical Schemes Act, the

Cancer Association believes that it should be highlighted in the prescribed minimum benefits to make sure that it is clear and that concise information transfer is present and that it is adhered to when members are recruited, that members don't really understand what the broker service is all about and because of the uncertainty eventually it gets lost along the way.

ADV PILLAY (SC) Do you have any, information on what, role brokers, play currently?

PROF HERBST No I personally do not have any information or history on that.

ADV PILLAY (SC) Then you refer in your submission to the difficulty experienced because the management of pain and the management of symptoms for people with non-treatable cancers is not covered as a PMB, I wonder if you could just elaborate on that a bit?

PROF HERBST It doesn't only apply to non-treatable cancers, even in the treatable cancers, patients do not always get the pain control that they are supposed to and there are many fears around this and I think every health professional maybe has a role to play. People are afraid of addiction. People

are afraid that they will be targeted because they are becoming dependent on something like morphine or other pain controlling substances.

We also know that doctors don't want to prescribe over a long period of time, things like morphine to patients that they don't want to become known as practitioners who specialize in provision of scripts for morphine, so there is a complex situation why cancer patients are not getting the treatment that they should and the World Health Organization has a beautiful 3 step ladder program that is very well explained in the document that I have left behind for the Commission on pain control in cancer patients.

ADV PILLAY (SC) Thank you Professor Herbst and then on Page 3 of your submission, you say in the final paragraph on that page, that oncology benefits are usually said to be unlimited. I wonder if you would just inform us who informs potential members of the so-called unlimited benefits and when it is that they discover that the benefits are not unlimited?

PROF HERBST Patients are usually brought under the impression that they have unlimited, that they would be treated for their cancer as long as the cancer is a health problem to them and this apparently and we know in practice that this is not the case, that eventually when the benefits run out,

patients are not covered anymore and I have personal testimony of that, because my late wife died of cancer of the liver and she died in the middle of the year and for the rest of the year, I had to pay for my chronic medication out of my pocket because we were running out of benefits, so benefits and especially for the specific groups like oncology is not unlimited, but patients are brought under the impression that they will be treated for their cancer and it is not explained to them up to a limit of whatever.

ADV PILLAY (SC) In your experience who creates, the impression that the benefit is unlimited?

PROF HERBST Can you just repeat that question?

ADV PILLAY (SC) Who creates the impression that the benefits are unlimited?

PROF HERBST Mr. Chairperson through you, I believe that it would be misinterpretations of documentation provided by the medical insurer, or maybe even by brokers or by members of the different medical schemes themselves, that they do not make it very clear to patients and that because of what was not said, patients appear to understand that they will be treated for

the whole period that they will be suffering from their cancer.

ADV PILLAY (SC) Thank you Professor Herbst we have no further questions Chair.

JUSTICE NGCOBO Thank you. Professor Herbst I just want to make sure that the documentation that you have given us, forms part of the record of your presentation. All these documents as I understand it were researched and authored by, yourself, is that right?

PROF HERBST That is correct. I am responsible for providing all the health material of the Cancer Association and I have to that extent, written over two hundred fact sheets on the different cancers.

JUSTICE NGCOBO Yes very well and what is your specialty?

PROF HERBST I come from a health studies background. I originally started off as a professional nurse and was a lecturer at university in nursing, but eventually ended up as being a professor of health studies.

JUSTICE NGCOBO The first document that I would like to record, is fact sheet on top 10 cancers the population group.

PROF HERBST That is correct.

JUSTICE NGCOBO The second document is a fact sheet on cancer of an unknown primary.

PROF HERBST That is affirmative Mr Chairperson.

JUSTICE NGCOBO And the third document is a fact sheet on pain control in cancer.

PROF HERBST I affirm that Mr Chairperson.

JUSTICE NGCOBO Is there any additional documentation that you have made available which I have not read out?

PROF HERBST No Mr. Chairperson.

JUSTICE NGCOBO Apart from of course the oral presentation that you have prepared?

PROF HERBST That is correct.

JUSTICE NGCOBO And as I understand it, your concern is about prescribed minimum benefits, is that right?

PROF HERBST Correct Mr. Chairperson.

JUSTICE NGCOBO Which you believe do not cover cancer is that right?

PROF HERBST Sorry can you repeat that?

JUSTICE NGCOBO Precisely what is your concern about the PMB's?

PROF HERBST The Cancer Association would like to see that the Council of Medical Schemes will come up with a revision which they have promised over years and that before finalizing these, that they will consult broadly with all individuals and organizations and bodies that have an interest in these minimum benefits.

JUSTICE NGCOBO Yes and for the record, when was this review supposed to commence?

PROF HERBST When was what supposed to take place?

JUSTICE NGCOBO The review?

PROF HERBST The review has been ongoing for quite some time now already and whenever you make enquiries, you hear that we are busy with the

process or reviewing, but we don't see a final document or we don't have consultations coming our way to see what our views are.

JUSTICE NGCOBO Do you know precisely for how long that has been going on?

PROF HERBST No sorry Mr. Chairperson I am not in a position to say. Maybe I don't know whether there is anybody from the Medical Schemes Council here that could highlight that for us.

JUSTICE NGCOBO Do you know who are members of that reviewing committee?

PROF HERBST No Mr. Chairperson I don't have direct dealings with that organization myself.

JUSTICE NGCOBO But to your knowledge, has your organization received any invitation to make representations to that committee?

PROF HERBST I am sure that that will be the case Mr Chairperson, but as far as my knowledge goes, the opportunity has never arisen and we haven't seen any requests for people to come forward and to make submissions. I am aware that my colleague Ms {indistinct 31:33] who drafted the original

document to this Commission as head of advocacy from the organization, has been in contact with the Council of Medical Schemes not with much success.

JUSTICE NGCOBO Okay very well. Before we let you go, is there anything that you would like to say in closing?

PROF HERBST No there is nothing Mr Chairperson apart from, thanking the Commission for the opportunity, to come and present to you today, on behalf of Ms [indistinct 32:14].

JUSTICE NGCOBO Thank you Professor for your presentation and for the documentation that you have made available to us.

PROF HERBST Thank you Honorable Chairperson.

JUSTICE NGCOBO Thank you, you may go. Do we know who is next?

MS MUVANGUA Yes Mr Chair, the next is the South African Society of Cardiovascular Intervention.

JUSTICE NGCOBO Could somebody please take the responsibility of making sure that people who are going to testify, are ready to testify at the time when they are supposed to testify. Okay good morning now I understand

that this is a delegation from the South African Society of Cardiovascular Intervention, is that right?

DR KETTELS Yes Chief Justice.

JUSTICE NGCOBO Could someone perhaps indicate to us how you propose to make your presentation? Who is going to start and how you are going to proceed? You don't have to stand, you may be seated.

DR KETTELS I am Dr Kettels, I am the President of the Organization and we have prepared a slideshow that will illustrate our points and if that suits you, I would like to present that to you. That will be the sum total of our presentation.

JUSTICE NGCOBO Do you, want to present from where you are sitting?

DR KETTELS Frankly I am more accustomed to presenting standing, so if I may?

JUSTICE NGCOBO Be my guest.

DR KETTELS Thank you very much to the Commission for allowing

us to present, we thank you for your time and attention.

JUSTICE NGCOBO Perhaps, just also for the record, if you could, just place your name on record please?

DR KETTELS I am David Kettels, I am a Private Cardiologist working out of East London. I also work in the local State hospital doing sessions for State cardiology and for my sins I am the President of the South African Society of Cardiovascular Intervention. I will tell you who we are we are a Non-Profit Section 21 Company formed in 2003. We are a special interest group of the South African Heart Association and we represent one hundred and three full members who are interventional cardiologists and one hundred and nineteen allied professional members. These would be members who are Cath Lab nurses, Cath Lab radiographers and medical technologists.

We represent the vast majority of cardiologists performing coronary intervention in South Africa and it is estimated that around 90% of all coronary interventions performed in this country are performed by our members. It may interest you I am sure to know that there are only two hundred cardiologists in South Africa in active practice for our population and just interesting to reflect that if you estimate the incidences as on the

slide, one hundred and fifty thousand cases of myocardial infarction are expected in South Africa annually.

Nowhere near this number are treated, we are under-reaching our population quite desperately in fact and current guidelines tell us that all these myocardial infarction patients should have access to an interventional cardiologist for contemporary care. I take the liberty of for a moment…

JUSTICE NGCOBO May I interrupt you, I wonder as you go along with your presentation, you would be kind enough to explain some of those terms, bearing in mind that you are dealing with a layperson?

DR KETTELS I will indeed, in fact I have taken the liberty of showing in this slide, what we do. We are those who in the dark hours of the night, when patients are presenting to hospital with acute chest pains, disturbances of cardiac rhythm and heart attacks are the people who are treating them, that is a picture of a coronary artery. You can see a vessel at the top of a screen, it only extends for a few millimeters and then stops and it stops because it is blocked with a clot. That is the genesis of a heart attack.

What we then do, if I show you on the next slide, is we open that vessel and

we put the wires down the artery either working from the leg or from the groin or wrist, we suck out blood clots, we then splint that vessel with stents and you can see the entire vessel anatomy restored. This is contemporary technology to treat heart attacks and this is what saves lives, saves heart muscle and saves long term morbidity for patients. It is a highly specialized field to be an interventional cardiologist in South Africa at the moment. You would need a minimum of seventeen years of training.

This is just a cartoon really to show you blocked arteries. We specialize in putting wires down blocked arteries. We open these arteries with balloons we leave metal or these days, even plastic scaffolds behind to splint arteries and to restore blood supply to the heart muscle without which the heart muscle dies. Essentially, we are talking about a strategy for re-vascularization in that very common condition of coronary artery disease which is growing killer in our society.

More recent years have seen interventional cardiology expanding and starting perhaps to impose on what traditionally was surgeons' territory. We are physicians primarily, but interventional physicians and now, we find that for example, heart valve surgery which previously was the domain of open

surgery and required your chest to be opened to have a valve replaced, a very common condition in elderly folk, is that the aortic valve, the outlet valve of the heart becomes narrowed and this will cause death quite quickly in a matter of months when it becomes severe and symptomatic.

It has always required a major operation and an elderly person with a risk now we can indeed in some cases of high surgical risk, replace that valve through the groin by dilating and getting it out of the way and then implanting a stented valve which can replace the previously damaged heart valve. This is one of the newer aspects of interventional cardiology.

In the private sector, we function essentially with referred patients, referred to us by other colleagues. Very frequently, such patients are emergency cases and they often represent patients with life threatening illnesses that demand immediate action for best possible outcome. These are patients with severe chest pain, patients whose lungs are flooded with water and cannot breath, patients who are in the throes of a massive heart attack, patients that have dissected their aorta, all sorts of major medical emergencies which require highly specialized and immediate therapy to affect the outcome.

What is very gratifying for us, is that if you look at the contemporary treatment for example of acute myocardial infarction heart attack as it were, we can reduce the mortality of that condition to about 3% to 4% in hospital if we allowed to treat patients expertly and quickly. Of course we also do elective consultation work much of the time. We refer patients and out of interest, these patients that we see, would tend to congregate among those patients with those common diseases that have been discussed before the Commission for high blood pressure, disorders of cholesterol metabolism, diabetes and their complications in the vascular term. These are the predominant patients that interventional cardiologists would be treating.

So why are we here? We are here because our ambit is the doctor patient relationship. This is that magical interaction that we can have for perhaps a few minutes with a year with a patient who we routinely follow-up with cardiac disease, or in an emergency situation with a patient I suppose also with their family, but a very special place and a very special interaction and a confidential interaction which we find increasingly, is disturbed by a large third party which are funders and there are relationships between funders and their patients, we would love that these relationships were open, that patients

knew what they were paying for, what they had rights to access and how to do that, but we find that this is frequently not the case.

There is a big relationship between funders and doctors. Perhaps from our point of view, we would prefer that such a relationship did not exist at all, but we are involuntary co-opted into that and more and more of our time and the complexity of our practices considering a very highly under-stocked number of cardiologists more and more of our time is spent in dealing with funders and trying to help our patients achieve that for which they have already paid.

There is a reciprocal relationship of course between us and funders. One would hope that in our relationship with funders, we would be able to advise them when care was out of the ordinary what was required. We would perhaps be able to draw their attention to contemporary guidelines for practice. Unfortunately we are finding that sometimes such attempts fall on deaf ears.

In fact, we end up asking please Sir could I treat this high cholesterol or could I please place a stent, or I promise you, it really, really is necessary, this is the third time I am telling you this patient does need a pacemaker and I needed to use that balloon, that was the reason I did it, it really was a heart

attack, you can't force the patient to pay for that. You do indeed need an anesthetist to do a by-pass operation and the reason that this patient is in hospital, is because they are sick. These are no made up examples. These are questions and issues that I have to deal with on a daily basis in my practice.

So we find that there is a gross imbalance of power between funders and patients and let me list a few of those for you. Patients do not know their rights and nobody is telling them. Simple messages need to be conveyed to patients and understood by them. Messages such as that, chronic medicines should be provided without co-payment. Cardiac emergencies may not attract co-payment for hospital based interventions. I recently had to deal with a family who came to me after a successful by-pass operation and came to see their cardiologist 3 months later and I sensed a tremendous sense of despair and gloom in the room and I couldn't put a finger on it because the patient was thriving and until I got the family out and spoke to the patient alone and it turned out that he had just come from the bank where he had mortgaged his house for an additional R70 000 to pay for his hospital bill.

I personally got on the phone to the medical advisor. The bill was paid by close of business. He was unable to achieve that in 3 months of struggle.

Patients don't know that they may consult their cardiologist for an annual review under a PMB care plan allocation and that that cost will be borne by the funder. Indeed, the majority of patients who come through my office doors on a daily basis, will come and have their routine annual follow-up and if I advise them that indeed this money should not be taken out of their day to day benefits which is their own savings fund, they aghast does someone else really need to pay for it.

Of course if I tell them that, I shoot myself in the foot and just destroy the cash flow of my practice, because I will only be paid about 4 months later and I will have to fill in a 6 page form to tell the funder what they already know which is the diagnostic code and the treatment that is being administered. When it comes to next year's visit, I will have to fill the form in again.

How difficult is it for patients to get funding for important in fact critical but expensive items for life threatening illnesses? A patient of mine who is on the Legislate at Bisho, recently came to me absolutely angry, it was this week in fact. He has obstructive sleep apnea. It means that when he breathes, when he falls asleep, he stops breathing and the oxygen levels in his blood, decline to dangerous levels. A simple remedy is a machine which assists with

his breathing it costs about R4000 between that and R7000.

He has seen 3 specialists, he has had 3 motivations. After extensive motivations, we've done a sleep study on him, confirmed the diagnosis and sent that through to the funder. This is 3 different specialists. The funder absolutely will not budge. Only when he put in a complaint to the Medical Schemes Commission, was he able to access and then he received the machine within twenty four hours.

The best example for us, is the aortic valve replacement that I showed you, where it can be done percutaneously. An elderly person will come into my practice and require that procedure as a lifesaving procedure and they will see a cardiac surgeon who will assess them and say well this is very dangerous, your risk of dying during such an operation will be about 30%, I am not prepared to do the operation. It could be done percutaneously.

The funder will say you can have your valve replaced, but you can only do it if you do it in the way we say you should do it which is open surgery. Yes of course the operation may well kill you.

JUSTICE NGCOBO Sorry before you get to the next slide, in the case that

you have just mentioned, now what explanation is given for this delay. There were motivations but they wouldn't budge, but eventually it was agreed. What makes them to change their mind?

DR KETTELS Only, if we take it to the next level and make a complaint.

JUSTICE NGCOBO What sort of reasons is furnished for this resistance?

DR KETTELS Sadly no reasons are furnished and no communication will be forthcoming. This is one of our major difficulties. We have no way to know what is going on behind those telephone lines.

JUSTICE NGCOBO The individuals that you talked to, are these the individuals who have to make a decision, or are these individuals who still have to find out whether this is allowed or not, so there is a delay in the process, because it is one thing to go to the first person who says well, we have received your request, we are processing it. You make a follow-up, you get the answer that we are still processing it.

DR KETTELS Usually by the third time we approach, the answer is sorry the quotation you have sent through, has expired, could you please send

it all through again. That has been our experience over and over again. So it appears that the request for motivation often is not a genuine attempt to get information, but rather an attempt to delay the process because if you put enough hoops for the patient to jump through, eventually they will fatigue of jumping. Shall I continue Sir?

JUSTICE NGCOBO Thank you.

DR KETTELS So we have spoken a little bit about the relationship between funders and patients, so let's talk a little bit more about the power and balance between funders and doctors. In fact, if that little blue block at the bottom represents doctors, I would venture that the power balance looks something like that.

Who decides what sort of treatment is best? The funder decides. A good example would be multi vessel re-vascularization. I have told you that we are in the business of putting oxygen back into heart muscles through blocked arteries and many times, there is an option of treatment. You can have a by-pass operation, or you can have a multi vessel stent procedure which I showed you a cartoon of earlier.

Unfortunately we don't get to make the decision, because we ask the funder and they say no, we only pay for 2 stents, but we need 3 or we only pay for bare metal stents which is inexcusable use of old technology and really wouldn't give an effective outcome, the patient must have by-pass surgery. Perhaps an even more dramatic example, what ancillary imaging modalities do you need in our catheterization laboratory? Now this is technical so please bear with me, but sometimes when we treat arteries with stent procedures and balloons, we need more accurate information than we can achieve just by x-rays pictures and injections of dye.

We use a technology called intra-vascular ultrasound, it adds about R12 000 to a procedure cost. However, it dramatically changes the outcome of what is a life threatening procedure and a life threatening intervention. If I don't use the technology, the literature is clear, the outcome is worse. The funder however, when I bring the patient into surgery, it states on the front of the file, we do not have cover intra-vascular ultrasound and so, my ability to intervene for the patient is jeopardized.

What drugs should I use? I will give you an example of this very week in fact this was about 3 days ago, a patient comes to me, he has got a clot in his leg

after having hip surgery and part of that clot is dislodged and gone to his lung. He has a pulmonary embolism it is a life threatening complication, simply treated fortunately with 6 months of blood thinning anti-coagulation therapy. The traditional standby is Warfarin, it is very cheap, but it requires blood tests initially every third or fourth day and then weekly, perhaps then monthly eventually to control the level of blood thinning safely.

Now we have new drugs on the market. They go under the name of Noax Novel Oral Anticoagulants and they cost about R1000 a month, so for this patient to treat his pulmonary episode, R6000, I can discharge him today. However, in this case, I tried to get this through the funder, but they only pay for Warfarin, but Sir he will have to stay in hospital for a week on anti-coagulant injections in order to get the Warfarin therapeutic before he can safely leave hospital.

This is going to cost about R25 000, but the funder insists he must use Warfarin, so we use an inferior drug at 4 times the price, because of resistance to new technology, apparently just because it is new. There doesn't seem to be an understanding of what cost effective really means.

What about other funder doctor problems? Here is the key. When you decide what to pay for, it effectively means that you decide how to treat. My patients cannot afford to have an opinion different from the funder and that means that I also cannot afford to have an opinion different from the funder and my integrity as a practitioner is threatened. However, this would be okay and we understand that there need to be protocols, but then surely, they should be contemporary and evidence based.

Sadly, nothing could be further from the truth. I give you a personal example of simple daily therapy on the vast majority of patients who come through my office doors with cholesterol low statins for the reduction of serum cholesterol in patients who have had coronary artery problems. These drugs have now become dirt cheap and they are often flat-priced. In other words, as you increase the dose, the price is very similar, if not identical.

However, there are guidelines published by the South African Lipidology Association, there are international guidelines to which we adhere as to how to use these drugs. One example would be that when you have a heart attack and your arteries are inflamed with these cholesterol plaques you need a high dose of statin. We are talking about a drug that will cost on a single exit

price, about R85 a month. For a procedure of course that has just cost the funder R100 000 and to try and prevent that from happening again, but the funder will not pay for that drug.

They insist that we follow their so-called evidence based protocol, which means the weakest statin at the lowest dose and then a blood test in 3 months' time which costs over R300 to re-check it and then we up the dose and then we re-check again 3 months later. All of this is completely unnecessary, hugely wasteful. Of course it is useful for funders because those blood tests are paid for out of patients benefits and those repeat visits to the doctor and repeated filling in of forms, are paid for by patients, not by funders.

I have personally engaged with medical funders in my personal capacity, sent them the evidence based guidelines, sent them the South African documentation out of our local medical journal and the honest response I got from one medical directory, was that we will look at this when we think we can afford it. So the funders in fact decide how much we charge, I see that cardiologists are a very small fraction of specialists. I was surprised at how little that was, but we don't determine our own fees, funders decide what they will pay us and this is coercive in the extreme because if I decide to charge a

fee which I am allowed to different from what the funder pays, well then that money will be paid to the patient and I will possibly never see it.

So we are forced, essentially, to charge what funders will pay, or risk, bad debt. In our environment, different specialists will get different fees for the same procedure. It is a ludicrous system. If one kind of vascular intervention puts a stent in your carotid, he will chart a certain fee. If a different vascular interventionalist from a different discipline does the same procedure, an entirely different fee. The coding is absolutely chaotic.

I give you the example of cardiac re-synchronization therapy which is a by-ventricular pacemaker, this is an electronic device highly specialist to implant, which we use in patients with advanced heart failure with a weak heart muscle. This requires the replacement of a lead, an electrical lead in a vein of the heart threaded through from the neck veins here, highly technical, highly complex. I placed the first CRT pacemaker in my practice in 2002. Today, fourteen years later, there is still not a code that I can use to get remuneration for that procedure from a medical funder.

There have been code suggested, we put them through and they say no, they don't recognize that code. Fourteen years down the line, old technology. We

see the request for motivation often as a deliberate tactic to defer patients, payments to hospitals, to patients to care providers. Now in fact may I go so far as to say that very frequently, motivation requests from funders, we consider them the department of stupid questions and I will give you some examples.

Why did you use an FFR wire, if I may further tell you what we do in the catheterization laboratories every day, we move past the evaluation of angiograms just by looking at an angiogram and deciding how severe a lesion in that is. In other words, you see a narrowing, is it a 40% narrowing? Is it a 50% narrowing is it an 80% narrowing? This is hugely subjective, but we have to make decisions, does the patient need a bypass, does the patient need a stent, or does the patient need nothing at all. We have to make these decisions as we look at these angiograms.

We have technology, a wire that measures the flow accurately, it gives you an exact cut-off point, it is safe, it is quick, it adds very little to the procedural cost. In fact, it has been shown to reduce the number of stents placed, reduced by dramatic numbers, the number of patients referred unnecessarily for re-vascularization procedures. Every time we place an FFR wire for the

last 5 years in a patient's coronaries, we get asked 5 or 6 or 7 weeks later, to please motivate why we did it.

So as SASCIA, we sent out a statement on the use of fractional flow reserve in improving outcomes and we start to send that to the funders to say this is why we use FFR, but then they wise up to that and they say no, we want a patient specific motivation, this is not good enough, then we have to write in the case of Mr Smith, we used FFR for these reasons, because we always use it for exactly the same reason.

I have been asked why does my patient not have a drip, why did you use 2 angioplasty balloons, we haven't paid the bill because we want a motivation why did you use 2 angioplasty balloons, surely the answer must be because I needed to. Why did you need a second stent? Surely the answer must be because the first was insufficient. Why did you need to admit the patient to do a bypass operation? One facetiously writes on the form, because doing it on the coffee table in my consulting rooms was considered inappropriate. Why did you use angiographic catheters to do an angiogram? Because you cannot do an angiogram without angiographic catheters and so the department of stupid questions destroys our ability to practice medicine effectively and

doctor patient relationships is undermined at every turn.

Innovation must grind to a halt when anything new is ever considered inappropriate. We cannot introduce new technologies and eventually I suppose happens what is intended to happen, that service providers succumb and don't tell their patients what they could do, because they can't bear the thought of getting involved in the tedious and impossible motivation process. Dare I say it patients sustain irreversible harm and sometimes death.

I have no desire whatsoever to spend my precious time fighting burdensome bureaucracy in order to access the right to deliver old fashioned treatment to disempowered patients who despite paying substantially, most of their disposable to an insurance company are coerced into accepting second or third rate treatment options that are masquerading as evidence based protocols. Why are we here? We want to deliver world class service to as many patients as possible and we believe that South Africans should have access to contemporary care. The environment in which we work and are forced to work, is detrimental both to service delivery and the future of our discipline.

Interventional cardiology unfortunately whether we want to or not, is going to have to explode. We are facing the cusp of a cardiovascular disease epidemic and this in 2016 is how you manage cardiovascular disease once established and we feel that we have to advocate on behalf of our patients and our population. They are often unaware of the treatment modalities they are being denied, the drugs and devices that are being ignored and the loss that our nation would sustain if we allow our pool of interventionalists to continue to shrink and this [indistinct 1:02] to be so diluted so that we become irrelevant to the care of our nation.

Unfortunately as individual cardiologists, we have absolutely no chance of defending our discipline and our patients against funders as we discussed already, our approaches are simply ignored, certainly never responded. In fifteen years of writing, I would say countless thousands of motivations I have never received a personal reply, well perhaps 2 or 3 times. We have no means and no right to stand together, for such a decision would be seen as collusion and so we just want to give you a different perspective. There are very few of us. Those of us, who are still here, are committed.

We love what we do and we want to be able to continue to serve and equip

the next generation, thank you for your attention.

MS MAVANGUA Doctor I have 2 very quick questions. The first is you told the story of how you were able to get the medical scheme to pay the R70 000 on behalf of the patient. This is not the first time that we are hearing a story like that and my question was where do you think the gap? Why do medical aid schemes seem more inclined to not listen to their own members?

DR KETTELS Unfortunately it is not the only story I could share with you, but I have no idea why they are not inclined to listen to their members. I think you would have to address to them.

JUSTICE NGCOBO Yes Sir you want to add to that question? Please state your name for the record?

DR THERON Mr Chairman I am Doctor J.P. Theron, I am also a private cardiologist and I am the Chairman of the Private Practice Committee of SASCI. In my opinion, I think the problem lies really with the schemes in that it is a mechanism to reduce costs simply.

If you take a hundred patients where they need X treatment and you pit these kinds of obstacles in front of them and they are not aware of their rights and

they really not, most patients don't understand what a PMB condition is for example, I think the funders are aware that they can get away with it, so unless you find a doctor who is willing to go the extra mile to redo the applications and even possibly threaten to report the medical scheme to the Council of Medical Schemes, it doesn't get taken further and often these things just get dropped, so I think there is a certain percentage of patients that don't get the treatment and at the end of the day, that saves the medical fund the money.

Where that patient has ended up with a doctor that is willing to put extra time and effort into explaining what their rights are and to perhaps write something that is perhaps a little more threatening or to find out who the medical advisor is and to get hold of them and speak to them personally, I think those are cases where eventually, it does get paid for, but if you have to go through that kind of process every single time, it becomes very difficult.

MS MUVANGUA My second question was your presentation seems to in part have been that funders decide what treatments patients get and what procedures should be carried out. I wonder do they ever provide a basis on which they say these things? I mean you went and told us a story of how

Warfarin was insisted on. Did the scheme ever provide a basis on which they say this? Are they medically trained?

DR KETTELS I believe that they are advised by those that are medically trained. Unfortunately they owe us no explanation and so very frequently, the answer is simply no, we won't pay.

JUSTICE NGCOBO Could this perhaps be attributed to an attempt by the schemes to protect their members to make sure that what they get, is what they require? In other words, could it be attributed to over-protection?

DR KETTELS Chief Justice, I wish that it were so. I want to just, if I may, give you an example of a colleague of mine, not a medical colleague, but let me say a friend of mine who also is a patient, who developed unfortunately a dilated cardiomyopathy a life threatening weakening of his heart muscle, so that his risk of sudden cardiac death becomes extremely high and the treatment for this is the placement of a defibrillator, it is a pacemaker like device with wires that go down into the heart which monitor the heart rhythm and can detect any lethal arrhythmia and keep the patient alive.

Also unfortunately an expensive therapy, the cost of the device and the leads

alone, is about R140 000 and so when my friend reached the stage that this was indicated according to contemporary guidelines, I wrote to his funder and requested, I sent them the ECG's, all the appropriate indications and a beautiful highly academically correct letter detailing exactly what was required, quite happy to have the funder say we do not cover this in terms of the provision of his scheme.

Unfortunately no answer was forthcoming. I had an appointment to see him for review in 6 weeks. I got him back, no answer still forthcoming. I got my practice manager to phone and they said they hadn't received it, so we sent it again and this went on and I won't bore you, but this went on for 6 submissions to the medical funder. After the fifth one, they wrote back and said he doesn't quality for a pacemaker. I phoned them immediately and said as you are well aware, I did not ask for a pacemaker, I asked for a defibrillator, you have all the documentation. I had sent them 3 quotes by that stage from different companies.

When he came to see me eighteen months later, having been at risk of sudden death for that period, I said enough and no more and the only recourse I could think of, was to go to his broker and say to him, you sold this man this

insurance policy, I am unable to get any wisdom out of them and could you please intervene and he did. Within forty eight hours, the device was approved and a doctor had phoned me and apologized. That was what it took. It is not about protecting patients that I can assure you Sir.

ADV PILLAY (SC) Chairperson we just have 2 questions. Doctor one of the issues which have arisen from submissions made to the inquiry is whether or not there should be a duty on the practitioner involved to advise the patient or the member that the condition diagnosed constitutes a PMB. Do you have any views on that?

DR KETTELS That is an excellent question. In my practice, with an ever increasing burgeoning population of administrative staff trying to deal with these matters, we are now informing our patients I work in a very blue collar part of the country, my patients cannot afford co-payments, they cannot afford to pay my fees out of pocket and so we inform our patients and we have pamphlets in the front room of the practice, telling patients these are your legal rights under the legislation and the Medical Schemes Act, so for me, I believe that we should do that. That is a personal opinion.

ADV PILLAY (SC) Are there any agreed evidence based treatment protocols or guidelines that could assist funders and consumers?

DR KETTELS Indeed there are so many of them, that it is overwhelming. As the South African Heart Association, we subscribe to the European guidelines we are closely affiliated with the European Society of Cardiology. At times, when we feel that guidelines need adaptation for South African context, for example, the lipid lowering guidelines that I referred to earlier, we will have an expert panel look at those guidelines and adapt them for context, but on the whole, there are guideline booklets which are freely available.

MR SELEKA As a follow-up to that question Doctor, one would have imagined that in the area of cardiology, that protocols that are given out by medical schemes, would have been drawn out by specialists in your field and if that is the case, the question is why is there conflict at the time of providing treatment, that you as a practitioner, you have a particular view and the scheme also has a different view?

DR KETTELS I think that is an excellent question and it speaks to whether indeed that assumption that such protocols are indeed drawn up by

somebody who is an expert in the field, are true. I admitted a patient to the catheterization laboratory yesterday for an angiogram and was slightly amused given where I was coming today, to notice on the front page of the patients file, we only pay for bare metal stents. Now bare metal stents were gradually replaced by drug eluting stents from about 2002 in South Africa and now, are only really used as a cost saver, but the cost saving is small and in fact, there are drug eluting stents that are almost the same price as bare metal stents.

If you put a bare metal stent into a patient, the risk of that vessel re-narrowing, is about 6 times higher the risk for a repeated very expensive procedure, is about 6 times higher and yet that protocol persists in 2016.

It is certainly not written by somebody who understands contemporary interventional cardiology I can assure you.

MR SELEKA And what does your association do in order to resolve that situation?

DR KETTELS We on an individual level, frequently motivate and we spend a lot of our time doing that as I hope I have indicated to you, as SASCI,

as I have shown you, one example on the slides, with the issue of FFR, where we find that a question is a recurring question from a funder and from multiple funders when new technologies are introduced, we will write a position statement on that, we will circulate it, we will put on our website, we will give it to our members and to funders and tell them where this fits into contemporary practice. Unfortunately that appears to have very little impact on how it is funded.

MR SELEKA In your view, what is, the role of the CMS the regulator in this regard? Does it play any role?

DR KETTELS Well we are very grateful to the CMS that on occasions, they resolve disputes and their intervention many times will see a patient receive the benefits to which they are entitled after a complaint is lodged.

MR SELEKA Yes but I am talking specifically in regard to protocols?

DR KETTELS It would be wonderful if they could test against contemporary guidelines, the protocols that are being used by funders, that

would be a huge step forward.

DR BHENGU Just to follow up, because I was also interested in finding out about the role that you as SASCI play on behalf of your practitioners, but I want to focus on what you do in a pre-emptive manner, what avenues do you have with funders to present this, to try and influence the process, because it doesn't help much to try and do it afterwards?

DR KETTELS We have relationships with funders as SASCI, I am attending a meeting with a funder this afternoon, but we find unfortunately that our interactions are very unsatisfactory and the best is for me to give you an example from December, where a practitioner in Johannesburg approached us and said guys can you help me, I have treated a colleague with 3 drug eluding stents for re-vascularization and the funder refuses to pay post-hoc. So myself and the Johannesburg colleague reviewed that case independently, we got the original case file, we looked at the angiography and I wrote about a two thousand word letter to the funder and said in contemporary cardiology practice, blow by blow, we defend our colleague, we believe that his management of this patient was impeccable in all respects, witnessed by the

excellent outcome for the patient.

I got a reply back from a risk management organization, we disagree, can you please give us references. Unfortunately there is no respect and unfortunately our attempts to engage and our attempts to educate, can simply be blocked and ignored. It becomes very frustrating. We are at the moment, in the case of that particular funder, within our executive committee, asking the question should we bother continuing to engage on these terms, because it is futile.

JUSTICE NGCOBO Are you done with your questions?

MS MUVANGUA We have no further questions.

LUNGISWA NKONKI Thank you for a very interesting and engaging presentation, you spoke a lot about evidence and the importance of using contemporary evidence and so I would like to know first from your side, I take it that you use the most relevant and latest evidence when it comes to effectiveness, but whether you combine that into cost effectiveness not just only cots of the drugs, do you have access to relevant evidence on cost effectiveness?

DR KETTELS Of course where possible and where process and time allows, we do try to appropriate guidelines for South African conditions. For example, the dyslipidemia guidelines, however it is certainly true to say that cardiology is a very technology based discipline and very often, the evidence precedes the cost effectiveness evidence. That comes a little bit later and certainly we adapt and that evidence sometimes changes practice and there have been recent examples of interventional procedures which a few years down the line, have been abandoned for lack of cost effectiveness, so cost effectiveness data definitely comes into it, definitely affects our practice very much, but is slightly behind the curve in terms of its generation.

LUNGISWA NKONKI A follow up on that is from the funders' side, in your engagements with them, do they present to you evidence of cost effectiveness or health technology studies that they have undertaken to inform the protocols?

DR KETTELS No absolutely not, in fact I have repeatedly requested funders to please send me their protocols and I have never met success in that regard. If I may regale you with yet another example, I had a young girl in my practice, I will say this with respect to those non-medical people, but with

HIV associated primary pulmonary hypertension in my practice this week, severe high blood pressure in the lungs as a result of infection with the HIV virus.

There is only 1 drug on the market in South Africa that can be used to treat that and it is quite expensive. I engaged her funder repeatedly over months, attempting to motivate for this young lady as the only therapeutic option available. I explained to them that her life expectancy was limited and we would only be able to treat her for eighteen months at best at a cost of just over R2000 a month.

I finally managed to engage a colleague representing the funder, they phoned me this week to say that the funder insisted that they wanted to know who did the echo cardiogram on which the diagnosis was based. An absolute red herring, insulting question to me in an attempt to defer payment and when I explained that one to them, the next question was we want you to take her to the catheterization laboratory, admit her to hospital do a surgical procedure with all the intendent risk to prove that she absolutely needs this. That procedure that they want me to do to prove that she needs it, will cost over

R30 000.

DR THERON Just to add to the question about cost effectiveness, I think we are cognizant of that and I feel unfortunately relies on a lot of technical stuff that needs to be imported and is expensive. I think one of the things that is really important is that we need to be able to engage with medical funders on an equal footing to discuss these questions and to really decide how these technologies need to be applied in our country.

There needs to be a balance and I think we do understand that as a society. We can't just say we need the best and the most of everything. We need to decide this is the situation, this is the treatment what are we achieving by this. One of the big problems that we have is that we don't have access to our own data. We generate a huge amount of data by just billing for procedures when we treat patients and that data goes to medical funders and we don't have access to that data and we have got to really get a third party actuary company involved for millions of Rand's just to get that data and if we had access to that kind of data, or at least an open relationship with medical funders, we would be able to have intelligent conversations about how

technologies need to be applied in South Africa in my opinion.

DR KETTELS If I may add one comment to that, regarding cost and technology, one must also bear in mind that there is a self-regulation process because the technologies that are brought in, are brought in by profit driven private companies who sell these technologies to us and they very carefully evaluate whether they think there is profit to be made quite frankly out of new technologies. There are many technologies that we do not have that are contemporary and new and expensive and perhaps not as dramatically effective in changing outcomes. We are not using such technologies, they simply don't make it into the South African marketplace because they would never ever be able to marked profitably because of the tiny number of patients that would have access to them

DRS VAN GENT Can I follow up on this subject?

SHARON FONN I think it is following on in this line of questioning. I think it's very helpful to have on record your interest in cost effectiveness and your understanding of that balance, because I think that is quite important, because one of the conundrums is around how much can we afford.

All the guidelines internationally take both cost and effectiveness into account.

In that regard, I want to understand a little bit more about the other work that your society does and what I am interested in, is if you do any peer review process across the society, if you take any actions or require any reporting to look at outcomes, to look at quality, how those work. You are not a professional association I understand that, you are a non-profit company so it is not your obligation to do it, but I am curious to know if you have any of those activities and how you among yourselves, assess your own standard of care and if you take any actions in relation to seeing a particular intervention not resulting in good outcomes, or a particular intervention that might be very complicated and so everyone shouldn't be doing it, that kind of thing I am interested to know.

DR KETTELS Regarding peer review, a funder approached us and said would we be able to recommend colleagues to be involved in peer reviews, so that where they believe coding is an outlier of a particular practice and coding appears to be inappropriate, could we help them examine that. We have absolutely provided 5 of what we consider to be our most

experienced and respected colleagues to do that and we now have a peer review committee to do just that, to look and make sure that our colleagues are not billing as outliers.

Of course, we have no jurisdiction over them whatsoever, but certainly, a gentle phone call and a nudge could perhaps be corrective in many of those cases. A primary interest in SASCI is in fact education, so we invest hugely and predominantly in educating interventional cardiologists and understanding that many of our trainees as they come out of university had not been exposed fully, to a contemporary interventional cardiology. We spend a lot of our energy there and in that very process, cost effectiveness and if we may call it super-duper specialization comes into it, in our community there is a clear understanding of individuals in the country that do certain things better than others.

There is a clear attempt to cluster for example, TAVI, which we have spoken about, the aortic valve implantation, is only done in 6 centres in South Africa. This is not done by any cardiologist. It requires an absolute commitment to the procedure to get better at it, to select the patients better to get better

outcomes.

Regarding databases, we've got on TAVI specifically, we have now got a share database to be able to look at outcomes, so yes, we do a lot to try to monitor our practice with particularly expensive intervention, predominately focusing on intervention and we recognize that not all interventional cardiology interventions for example, the opening of a chronically totally occluded vessel, very expensive, success rate in average interventional cardiology, hands 50%. Success rate in a person that is committed to that procedure, 95%, send the patient to the colleague who can do it better, so yes, we do do those things.

SHARON FONN Just explore that a bit further, when you were presenting your data, you presented it as absolute, we know this works. My experience in evidence based medicine is that we think something works until more data comes out and it is not that clear. Would you agree that there are cases where surgical intervention is appropriate? Do you have a range? Do you have a system where you say okay this is a surgical intervention and TAVI might work and it might be less evasive, but actually this patient isn't

at high risk for surgical intervention so surgical intervention is required?

The point I am trying to get to, is medicine by definition almost, it takes a while to know that something works, it is not something that we can be draconian or be 100% certain and I suppose from the funders point of view, they have to take this into account as well, so I am curious therefore to know what evidence you rely on? If you could give us some examples of the kinds of interventions, the kinds of bodies of knowledge that you refer to and that would be helpful to give us some sort of benchmark to understand you?

DR KETTELS Cardiology has in fact perhaps become now one of the biggest evidence based medical disciplines and we have an additional protection where technology is involved which usually is in our discipline, because we play with catheters and twiddle with wires and what not. Where such technological interventions are required, one must remember that they first need to pass muster with regulatory authorities.

So we have no possibility of experimenting on patients with untested modalities of treatment, nor would we wish to. In fact, we would only introduce into the South African market, a new technology would only be

introduced once it is passed regulatory, must become accepted in bigger markets, where it has been the subject of extensive testing.

If you for example look at TAVI, TAVI started off in an experimental program for people that were considered to be nearly dead and couldn't have an operation, high risk patients. It was then expanded to a slightly lower risk population as the technology was introduced and became better known. It is now well established and there are clear guidelines who should get it.

In fact, one of the requirements for example to be considered for TAVI, would be that you need to be assessed and evaluated by a multi-disciplinary team, which includes cardiologist skilled in the procedure, cardiac surgeons skilled in the procedure, a cardiologist not skilled in the procedure, in other words, a clinical cardiologist not an interventionist. Then only when it is decided that this patient is a candidate for valve replacement therapy, then the question becomes should it be done open, should it be done percutaneously, then the decision will be well the surgical risk, we have algorithms that we use, we plug in all the parameters of that patient, age, renal function, ventricular function, previous cerebral events etcetera. We then get a risk score, we look at the risk score, we wouldn't even consider the patient unless

they exceeded a certain risk score, they would all go straight to surgery and so then, we go to a funder and we say here is the motivation, here is the guidelines, this is an established therapy, we would like to put this patient forward for TAVI and then we get an answer we are not paying for those valves that you throw into patients.

SHARON FONN And last question, in relation to the suppliers, do they give you access to the HTA research outcomes? How easy is it to get from your suppliers and related to that, what is the nature of your relationship with the supplier besides purchasing? Do you or any of your colleagues have a relationship with suppliers besides purchasing the product?

DR KETTELS We don't purchase the product, we don't even have that relationship, because those are purchased by private hospital groups. I suppose we have a relationship in that we use the product, but I can speak for myself perhaps as a person who does a fair amount of teaching and travelling for education, absolutely no inappropriate relationship with suppliers whatsoever, completely independent. I have never been coerced by a supplier to do anything using anything, or prefer anything for any particular reason.

We do on occasion, give lectures for example at educational initiatives that are funded by suppliers and our ethical standard demands that the first slide of any presentation I give, would be to disclose any potential of conflict of interest, for example, I have once received a speaker fee from company X, that is as far as it goes and that will always be disclosed. So there is no relationship in purchasing profits, nothing whatsoever.

SHARON FONN Sorry then I want to follow up with a different question about the nature of your relationship with the hospitals. So how does that work in relation to cardiologists? You clearly need a lab you need all sorts of things. Are these in your own rooms, are they in hospitals? How do they get paid for? How does that system work?

DR KETTELS We are not allowed as I understand it, but please I may be wrong, but as I understand it, cardiologists are not allowed to own the catheterization laboratory for example. So the facilities where I work are provided in their entirety by the hospital and paid for in their entirety by the hospital. The billing from that laboratory in its entirety goes to the hospital.

The only relationship I have with the hospital, in which I work, is that I am a rental payer of premises that I use for my practice. That is not always the

case, but in my particular case for example, I have rooms which are in the building of a hospital group and so I pay them rent. All my equipment is paid for in my rooms by myself, quite a substantial capex in fact, but it is all paid for by myself. It does not belong to the hospital. All the equipment in the hospital is owned for, paid for and built for by the hospital. The hospital does not pay me in any way shape or form for the patients that I bring to their hospital.

DRS VAN GENT Dr Kettels I know the 5 main problems, I want to talk about 2 problems. Coming back to the lack of trust between you and the schemes that is underlying all that you have been referring to, is a lack of trust no matter whatever health assessment technology you come up, there is a lack of trust between the schemes and yourself, maybe because they are not for profit and you are in a sense and there is also a lack of trust between the patient and the scheme as you informed us.

There is a need for health technology assessment and cost effectiveness assessments. Who to your idea, considering the lack of trust, should be responsible for doing these studies, is that an organization? Is that a current partner in the industry, or is that a new partner in the industry that should be

responsible?

As you might be aware in other countries, there are separate institutions responsible for that, precisely for this reason.

DR KETTELS I think that off the cuff, my first concern would be that it be uniform and applied to all funders so that we can have some clarity. The problem that we face, is that there are a multiplicity of funders and of course in my doctor patient interaction, the first question if I want technology when I have that patient sitting in front of me, is I have to look down and see who is funding you, because then I know what I may or may not be able to fight for.

So uniformity would be ideal and I think that that means that such an assessment and evaluation of evidence would have to be taken away from individual funders. My next would be that whoever makes that decision, would have to engage with those involved in the contemporary care of patients together of course with health economists and those that understand money better than we do.

There is a perceived conflict of interest in us pushing for higher technology, but I just wish to assure you and members of the panel, that very frequently

the use of high technology, will actually cost me and in fact, my recommendation to a patient will be no you don't need a stent, go home, everything is fine, you just need some tablets, if I can possibly get them out of your medical aid.

So the use of technology is not an evaluation of technology. We do not always have that apparent conflict of interest. Very often, we would like to save the patient's money and so we do pay attention to that very carefully, but I think it would have to be an independent body, it would have to be staffed by those who are actively and currently engaged in the field and I think it would have to be in collaboration with professional bodies that exist across the country that do pay attention to this.

We spend personally enormous amount of money and energy every year to stay on top of our field and it is utterly disheartening to be told you don't know what you are doing, we know better. It cuts to the core of everything we do when your patient comes to you and says but my medical aid says I don't need it.

DRS VAN GENT It appears to me to be a general problem in South Africa, it is not only your section that is struggling with it. Is there any

initiative taken by the medical specialists in South Africa as a whole to tackle this problem, to put this on the agenda?

DR KETTELS I think the biggest problem that we face as individual practitioners, is the legislative environment in which we practice, means that we are independent practitioners and we are not politicians and most of us are extraordinarily busy and we don't frankly have, or I don't have the diplomatic skills to deal with these issues, so I think that as a collective, I am personally not aware of that. It would be hard to achieve, we are by nature of our practice setup and our lives, we are fragmented and this is probably, I think you have identified one of the key barriers to such interactions.

Collectively, we cannot stand together for example and discuss fees, collectively billing I suppose we can discuss protocols, but we face enormously powerful opponents in that dialogue and they also are not united. It would be a question who do we address to, because each of them does their own thing.

DRS VAN GENT I have a different question on a totally different issue. On your sheet number 20, you spoke of different specialists will get different

fees for the same procedure. That is true and is that an implicit plea for regulating the tariffs of medical specialists?

DR KETTELS I think the tariffs of medical specialists are de facto regulated, because we have to charge what the medical funder tells us to charge in most cases. Certainly if you work in a part of the country that is not Sandton and where the patients will be prepared to make a large co-payment, essentially we do not determine our own fees, although we are allowed to, we essentially end up complying with funder driven fee models.

DRS VAN GENT Plus eventual possible co-payments?

DR KETTELS In certain instances, yes.

DRS VAN GENT Which build up to the situation that you alluded to that different specialists get different [indistinct 1:41]

DR KETTELS No sorry if I may correct that, what I was meaning by that was if I, vascular specialist A who happens to be a cardiologist and my colleague vascular specialist B from a different sub-discipline is also a vascular specialist, bill according to medical aid tariffs for the identical

procedure, then the medical aid set tariff for that procedure will differ substantially.

DRS VAN GENT Now we are touching on the subject and there is an understanding on my behalf of what I read into your words, so can I have your personal opinions on the subject of regulating medical specialist tariffs? As you know, I am from Europe and in Europe, in most countries, medical specialist tariffs are maximized and standardized. How do you look at that from your South African perspective?

DR THERON There needs to be uniformity regarding procedures and what we are doing and that kind of thing and I think a very good example of that kind of system, is for example the NICE Committee in the UK where economists get together with professional societies. We are sitting with a situation with individual medical funders getting together with their own so-called identified experts instead of a professional society in making these decisions individually.

If we had something for example like the NICE Committee where professionals were taken seriously and the economics of the situation could also be explained to us so that we can understand, then I am sure we could

reach some sort of good consensus which will be beneficial for everyone. In terms of the other question regarding standardization of fees, there are 2 aspects to that as well. If you look for example at the US system a CPT4 coding system, it is basically a system which doctors use to describe what they do and it is a very good system, we don't use it here in South Africa although some of the hospital groups use it and some of the medical funders use it.

We use the SAMA billing system or the SAMA coding system which is very disjointed and not a very good system to be honest. So the CPT4 system not only describes the procedure, it also compares different procedures to each other, so what is a consultation in a GP's room in weight versus an appendisectomy for example, so it gives that kind of what are procedures worth in terms of valuing it against other procedures.

What we have at the moment, there isn't that kind of uniformity. Some societies have broken away and said we are not adhering to this, this is what we are going to do, other societies are adhering to it, there has been changes made to it throughout the years which has perhaps led to some sort of

imbalances like Dr Kettels alluded to between different specialty groups.

If we look at standardizing fees again, it needs to be a uniform process along all aspects of medicine, not just one specialty group or just specialists, just GP's, you've got to look at the whole system and you've got to look at what the rest of the world has done and how do you compare these different things to each other and then a person can only start looking at tariffs and saying okay, now that we've got the fairness worked into the system between different procedures, different practitioners, how can we reimburse people fairly as well.

DR KETTELS If I may add something to that comment, I think it is worthwhile bearing in mind the history of private medicine tariffs in South Africa, where at one time, the so-called traditional medical aid tariff and so-called traditional SAMO or Medical Association as it was at that time tariff, were identical and gradually over the years, as tariffs began to be determined by funders and were not inflation related in any way, the SAMO tariff and the medical funders tariff gradually diverged to the point where I think it was about twenty five years later, they were 300% apart. This would be a problem, to get an adoption of such a system, there would need to be trust

that practice inflation studies would for example be taken into account, cost escalations etcetera.

MR BHENGU Sorry Doctor I have to take you back, this is regarding the laboratory that we referred to, when you made reference to Cath Lab, the way you put it, it seemed like specialists who practice at a particular hospital have no influence in terms of what equipment is sourced by the hospital.

DR KETTELS No not at all.

MR BHENGU That is not my understanding, but I wanted to find out exactly what that process is in your experience in terms of deciding what needs to be bought, bearing in mind of course that there are different interests. Not every cardiologist would necessarily be part of your group or whatever and of course, because you have made a very good case for example of how the doctor patient relationship is interfered with, but the reality of supply and just demand is a reality as well and that is the balance that you are talking about that we need to strike, so this is why I am interested in finding out, that decision that says this equipment must be bought and once bought, if there is any implied or outright expectation in terms of utilization rates to recover costs, so it is a very direct question there.

DR KETTELS I can only answer this from personal experience because I have no knowledge of what has happened in other private hospital group contexts or private doctor contexts, so let me just tell you what happened in my context. I was working in the United Kingdom in 2000 and I was approached at that time by Afrox Health to start a cardiac facility in East London where there was no such facility and once I had expressed interest and a group of physician specialists assured me that they had done a feasibility study of the number of patients who were being referred out of town and that this was a necessary skill that the city needed, I was then flown to East London from where I lived in Brighton UK and came and met with the hospital management who interrogated me on my CV and competence and told me what they had in mind and would I be able to deliver such a cardiac unit and they told me of the other staff that they had been trying to recruit to do just that.

Eventually after a process during which they didn't pay me anything whatsoever, I decided to move to East London and then we had a subsequent meeting where we got tenders for the catheterization laboratory with me having explained to me what the specification of the model catheterization laboratory would look like and so they then put out a tender to multiple x-ray

service providers and I sat with the hospital engineering manager and the hospital manager and I think the regional manager of the group, as well as a couple of my other staff members and listened to some presentations.

Once I had decided which catheterization laboratory I thought represented for their company, the best value for money and the best specification, they told me you can't have that one because we have a better service contract with another provider and in fact, my input was totally disregarded, so regarding the catheterization laboratory that I work in, I didn't choose it. I did make sure that it was up to an appropriate specification, I have no ownership in it whatsoever.

However, subsequently in the laboratory a technology that I didn't mention, rotor blade, sometimes when we can't balloon vessels, we drill them out with a high speed diamond drill. It is an expensive technology. To have a consult for that, costs about half a million rand. We reached a stage with the volumes of work we were doing and the complexity of the work that we were doing, that we needed to expand our capacity to include that technology, I approached our hospital manager and told him that we absolutely have to get this into our lab now, so please can you consider this and he said it would

come in next year's capex budget and indeed it did. Again, I have no input into that, but certainly my voice was heard and recognized. So we would be advisors to the hospital in terms of what they need absolutely.

MR BHENGU I heard you, but I was hoping that you would give us a sense of what happens more often than not and not so much necessarily your particular situation.

DR KETTELS If I can just clarify one thing for you, let me be brutally honest with you here, when our catheterization laboratory was purchased, I asked our hospital manager why don't you let me purchase it and he said it is absolutely not acceptable to the hospital group and they would not allow it whatsoever.

DR THERON Maybe if I can add, we are in the process at our hospital of upgrading our Cath Lab and they have decided to, I don't suppose I should mention specifics, but they are in the process of upgrading, so how the process started, was our Cath Lab actually reached the end of its life, we are still using it, it is about twelve years old now and we are starting to get problems and they recommended that we should get a new Cath Lab.

They are also in the process of going to build a new hospital and the whole hospital is actually going to move to the new hospital and we ideally wanted to wait for that before doing anything, but they have insisted that we upgrade it. So they first told us about the situation and they said it is time for us to do this and they need us to meet with 3 different companies together with them, so what they did, they got 3 different companies to give us separate presentations on the benefits as well as the deficiencies of each system.

We were then given the quotes as well, so they were very open about what the costs were, so we could see the differences in price and we were obviously asked what our needs are. Then the next step was they took that information and they did their own analysis and they came back with technical specifications with their own idea of what pros and cons were and then they asked us again to go through all of that and then to argue what we would want.

The particular hospital group in question has an agreement or should I say a contract with a certain company that provides Cath Labs amongst other things and there is, but it is not an absolute contract, apparently there is a certain amount of leeway built into that contract, so we actually preferred a device

from a company outside of that contract for various reasons. There were 4 of us at the hospital and we all agreed and we went to quite a lot of trouble to explain to them why we preferred the alternative for clinical reasons.

They have taken that seriously, that is all I can say, because the process isn't complete and the next step I have heard, is that they are presenting our case to the board of the hospital and they will make the final decision, but at the end of the day, ours is just a recommendation and what they eventually purchase, will be decided by the board and the CEO of the hospital group as far as I understand it.

I think the thing that is on everyone's minds, is that are there any sort of financial incentives especially perhaps after the purchase, in other words, let's say we bought X machine, I think a Cath Lab is probably a bad example, but there are other things that we could talk about, if we get this machine we need to do X number of cases to pay for it kind of thing.

I am personally not aware in my career, of that happening to me or anyone around me. Those, such of things are such a big no these days, if you got caught doing anything like that, I think your career would be over instantly. I don't think anyone on an organization like SA Heart or SASCI would in any

way, condone something like that and if anything like that was taking place, as a profession, we would condemn it outright and I am aware, I have heard in media and things that these kinds of things do happen occasionally, but amongst cardiologists, to the best of my knowledge, I have never heard of anything like this happening and if it was, I would condemn it 150%.

MR BHENGU Now moving into the equipment that is owned by you, just a step back, hospital allocates rooms, there is a question of whether those would be on a market basis, the rental or is it discounted and it may or may not be linked to the expectation in terms of what work you do in your rooms and what you do that generates revenue for the hospital as well.

Now the decision to actually acquire equipment to use in your rooms, is this an easy decision to make? Is it entirely your decision to make? We are aware that some of the benefits from the medical scheme side are now structured in the manner that if you do procedures in your rooms, you as a practitioner, will actually earn more than if you were to do that in a hospital facility like theatre.

You can see the incentive is to basically make sure that while you might get paid more as a practitioner, but the total bill is less because it is minus the

theatre component for example, so I am trying to find out that given that it is actually a privilege to get rooms, are you otherwise entirely empowered to make the decision of buying and keeping equipment which ultimately reduces revenue to the hospital?

DR KETTELS I think probably cardiology is the wrong discipline in which to interrogate these questions, because it doesn't directly apply to us, but let me try to answer that for you as best I can. In my rooms, the equipment that I use, is an integral part of my clinical assessment of a patient and is limited to cardiac ultrasound or echo without which I cannot evaluate a patient and ECG equipment without which I cannot do my professional work. This is a basic core function of a clinical cardiologist.

The hospital has got absolutely no benefit from me owing that, nor do they have any interest in the equipment and nor do they have any influence whatsoever over equipment that I have. I dare say they would be completely unaware of what equipment I have in my offices. There is no benefit to them whatsoever. In terms of having rooms, when I had a negotiation with my hospital manager when I moved into rooms in the hospital 4 years ago, I said to him that I thought that the rental was outrageous and he said to me we are

obliged by our principles to have market related rentals, you will pay this rental or go somewhere else.

So in my context, certainly we pay to the best of my knowledge, market related rentals. The equipment for us, there are, no procedures as a cardiologist, where I have discretion as to whether that procedure should be done in my office or in a catheterization laboratory unfortunately. We are not involved in minor surgical procedures where that decision could be made. For me, an angiogram is done in the hospital and an ultrasound is done in my office. There is no discretion in that equation.

MR BHENGU It could very well be that I had in mind, maybe general surgeons, but I heard one of your gentleman saying that they were not given an option to acquire.

DR KETTELS Yes that was me our hospital group would flat out not allow that.

JUSTICE NGCOBO You mentioned in your presentation under the imbalance of power between funders and doctors that funders effectively decide what doctors should charge. What do you mean by that?

DR KETTELS When a patient comes to see me, the care that I give, is encapsulated in a particular billing code perhaps for an elective consultation in office hours in the rooms, would be one code. I have done a limited echo-cardio graphic examination of the patient's left ventricle there is another code to encapsulate that, so there will be a list of codes generated and an invoice generated according to precisely what service has been delivered.

The fee that I then charge is as I understand the legislation, I am entitled to charge what I consider fair and what I would be able to justify in terms of my practice overhead and experience and what no. In my context, the reality is that patients do not have a lot of disposable income, they are insured, they are seeing me as a private healthcare practitioner because they are insured and therefore for me, in reality, I charge them the fee as set down by their particular funder for that particular code and that will differ from one funder to the next.

JUSTICE NGCOBO But of course that is not true for all the specialists is it?

DR KETTELS Absolutely true.

JUSTICE NGCOBO I mean one finds this notice at the reception which says we are contracted to medical aids, so you have to pay and invariably, there may be a huge difference between what the doctor charges and what the medical aid charges. Now what makes a specialist to set up a practice from hospital A as opposed to hospital B?

DR KETTELS That is a question which I am afraid I have no experience of. My personal belief is that it is largely driven by personal issues related to where you want to live and what is available in that area, but I think that since I come from a city where there is 1 private hospital group, I think I will let JP answer that, as he comes from Johannesburg where there are many competing groups.

DR THERON I have experience of working for more than 1 hospital group, so maybe I can answer this. I worked as a cardiologist in the State for approximately 7 years and then I decided to go into private practice and I went to university in a small town and I was afraid of moving to a big city like Johannesburg. A place like Johannesburg obviously has a lot of opportunities because of the population and that kind of thing, so when I first went into practice, I chose to move to Pietermaritzburg which is a small town

and we were there approximately a year.

Obviously it was very similar to what happened to Dr Kettels. They gave all sorts of facts and figures trying to say this is the number of patients that are referred to Durban, we can retain the patients in this centre and we need someone to come and do that and I went into it sort of open heartedly and at the end of the day, the reality did not match what was promised and it was purely a financial decision. I couldn't maintain running a practice with the number of patients that I was getting in that area, so we started looking around again and that is when we decided to move to the South of Johannesburg where I was contacted by another cardiologist who said they are so busy, they need help.

So I think one of the main reasons that specialists will move to particular hospitals, is obviously where there is work, where there is availability and I think there is an unfortunate tendency in private practice especially for and I think the private hospital groups are guilty of this, is they see Cath Labs, they see cardiology as a money spinner and if you open a Cath Lab, you will get patients and unfortunately I think in my opinion what this is doing, is really

diffusing the expertise.

We need to identify where the need is, where, are, the centres of excellence and work on those and this isn't really happening in private practice. I think there are a lot of Cath Labs standing empty in private practice. I know there are issues in State healthcare as well, but I don't think I am qualified to comment on that. There are Cath Labs that are really under-utilized in private practice that were built for the sole purpose of attracting cardiologists and hopefully attract patients and I don't think that is right.

Where we are at the moment, we are a strong team, we work together, we each have our particular interest, we've got 2 cardiothoracic surgeons that are there fulltime, we discuss cases together and that is ideally what we want and I think that is the same thing that you have in East London, so the other reason I think people go where they want, you will see there is often a tendency for people to stay in towns where they studied, because it takes so long to become a cardiologist.

Many people have families, they have built up friends, they have children who are going to school, so they tend to want to stay in the towns where they studied and a perfect example of that would be Bloemfontein, that is where I

studied and I've got a lot of colleagues that I think have stayed in Bloemfontein working in private hospitals there where perhaps the need isn't as great and some of them are struggling a little bit, because of that.

JUSTICE NGCOBO Some of the submissions have told us that hospitals subsidize the rooms of specialists. They also offer them shares in the hospital. Do you know about that?

DR THERON That is correct, I am aware of some of these share programs. I haven't personally been offered any of these. I have heard that some of these share deals or whatever you want to call them that have occurred, occurred previously. I am not aware of any new programs like that. Certainly no one at the hospital, like I said there are 6 of us are involved in those schemes. Obviously if someone came to you and said here are shares in a hospital, no one is probably going to say no, but the problem is that is that ethical, especially if it is at the hospital that you are working in. I am not aware of any new things like that, but there are definitely people that are involved in that kind of thing, so yes that does occur.

DR KETTELS I believe there are so some historical arrangements where for example a big player in the private healthcare market has bought up

some previously independent private hospitals and there has been an ownership share of those previously independent doctor owned private hospitals where ownership has been retained by that group of doctors.

I know of a very few examples through the country where some hospitals that are functioning under the banner where a big corporate, there is a small percentage ownership that where shares are owned by practitioners, historically where those hospitals previously were owned entirely by such a group of independent practitioners.

I am not aware that this is still occurring or being allowed to begin like that, I am not aware of any contemporary examples, only historical examples where residual ownership has been invested in such groups.

JUSTICE NGCOBO These specialists who practice from hospitals, do they take part in a decision, who are the additional specialists to be invited to practice from that hospital?

DR KETTELS My experience has been no, have you JP had any input?

DR THERON In terms of if an additional specialist wants to come and practice at a particular hospital?

JUSTICE NGCOBO In other words, is there a committee that is responsible for making decisions as to who do we need, who can we invite to come in? Are there such committees?

DR THERON I don't know of any such committees, but I think it usually comes from hospital management if for example, there is a need for a particular specialty, then the hospital management or the hospital group will say they need say an intensivist or intensivists and then people who are interested, would contact the hospital management, but I've never as a specialist, been asked to look at someone's CV or something like that.

DR KETTELS If I may further answer your question, unfortunately for us, if I can regale my personal experience, is that we are very often sitting in a position of beggars cannot be choosers. I sat as the sole cardiologist in my city for about 3 years working absolutely inhumane hours and subsequently was fortunate when a person whom I had never met before and didn't know existed, came and asked if he could come and work with me.

I had never met him before, no knowledge of him, I was absolutely delighted that somebody was going to come and share the burden and when our service provision expanded over the ensuing 10 years, 3 years ago, I went to our hospital manager and said to him in desperation having been on call twenty four hours out of every forty eight for the last twelve years, we desperately need more hands on deck, please do whatever you can to find somebody and we were very fortunate that 3 years later, we were able to find another cardiologist who was prepared to come and work, so it has never been a question of being able to select. There just haven't been enough bodies to select from.

DR THERON If I can just add to that, when I was working in the State, what used to happen was that every year, each hospital group would have a recruiter you could call it appointed and that recruiter would contact all the different universities and say they are looking for cardiologists or they are looking for general surgeons and then they would ask the relevant department for names of people that are close to completing their studies or already in the system and whether they can get their contact details and contact them. I got contacted through several people like that when working for the State asking me to join their hospital.

JUSTICE NGCOBO Now when a patient approaches a medical practitioner, invariably the patient may have a sense of what is wrong with him or her, but cannot describe precisely what is the problem, so the decision as to what is wrong with the patient, lies with the doctor. Secondly, the patient has no knowledge of what treatment he or she requires for that particular ailment. Again, that is a decision that must be made by a doctor.

So in other words, it is a relationship that depends pretty much on trust. You trust that attending doctor, would properly diagnose what is wrong with you and would provide you with the treatment that is appropriate for your needs. The patient has no way of assessing either before the treatment or after the treatment, how good or bad the treatment was, is that right?

DR KETTELS I would hope that in many of the treatments that we offer, the efficacy of it would speak as a testimony to its correctness.

JUSTICE NGCOBO But invariably, they don't have a way of assessing whether it was good or bad?

DR KETTELS Or perhaps I could have done it differently.

JUSTICE NGCOBO Right, now given that circumstance, is there a need for someone to look after the interest of the patient, firstly in relation to whether the diagnosis that is made in the first place, is accurate and secondly, whether the treatment that is offered, is the appropriate treatment and secondly, whether whatever else is used, is appropriate for that particular ailment, is there a need for someone to do that?

DR KETTELS I personally believe that we couldn't contemplate addressing that apparent need in every consultation for every patient. I don't think that would be completely impossible to resource. It would require a second subsequent consultation for every consultation. I think that you have mentioned the word trust this is where trust and skills and ethical behavior becomes paramount. We have to trust largely I believe that the doctors that we are training, are trained to make these decisions correctly and that will have a culture of self- measurement and evaluation and peer review engrained in them from their early days at university. I believe that that is integral. I also believe that we face and I encounter this in my practice every day, an ever increasingly educated patient base and pardon me for the colloquialism, but doctor Google is alive and well and many patients that walk into my

practice, are surprisingly well informed about what they believe is wrong with them.

They are very well informed about what they expect from me and quite happy to criticize and debate the treatment options which I offer to them. I personally don't see any way that this apart from protocols that are evidence based, being used to evaluate global practice in terms of a statistical exercise in a given practice. I don't think we would be able to enforce the ethics, the appropriateness the skill of that interaction in terms of an individual event. Perhaps globally we can look at trends, globally we can look at diagnosis, we can look at interventions, is the right amount of interventions coming out of this group and we can look at trends like that, big mega trends. On the individual interaction, I think it is always going to be left to trust.

JUSTICE NGCOBO What if that trust breaks down?

DR KETTELS Then we have a rogue or incompetent practitioner that needs to be disciplined and identified.

JUSTICE NGCOBO Would that not be the role perhaps of the medical schemes?

DR KETTELS I don't believe for a minute, that that is the role of medical schemes. I believe that that is the role of the Health Professions Council and they certainly do do that. I see medical schemes as an insurance company to help patients cover their medical costs.

DR THERON If I can just add to that, someone earlier mentioned that medical schemes are non-profit organizations and I think legally that is correct, but we all know that practically that isn't correct. They are run by administrators which make huge profits every year. I am speaking under correction, but I think Discovery Health administrator's profit net was in the region of R6 billion last year?

It is one of the strongest performing companies in South Africa at the moment. There are big profits involved and I don't think that a medical scheme is really in the best place to look at that kind of thing. I understand what you are saying in that what happens when that trust breaks down and definitely there are rogue operators, there are doctors that don't have their patients best interests at heart, we hope that that is the minority, but should those cases occur, there is the Health Professions Council and fortunately the Health Professions Council patients that I have spoken to and feedback that

we've got is that they are not very helpful in that regard.

The issue with medical funders as well, is that they don't employ a cardiologist for example to look at cardiology issues. They will employ a general practitioner perhaps that has got an interest in healthcare management that is perhaps further educated in that field. What you really need is a strong professional society in a country that represents cardiologists for example who are respected and that their opinion is taken seriously.

At the moment, we give opinions, we give peer reviews and we are capable of giving peer review about cases. So I think there needs to be an understanding that these are complex issues and people that understand them, need to give opinions about them. There is a peer review committee which is independent which does look at certain things and like Dave said, we have had some peer reviews put forward.

The problem is that we don't really know where we stand and what does it mean? We can give an opinion, but that is actually all it is. I think it needs to be more than that. I think a professional society needs to police its own members and we are unable to do that simply because we don't know where we stand and the ideal would be if a patient was injured say for example by a

cardiologist and he felt that he was handled incorrectly, the first thing he would do, would be to go back to that cardiologist and say look what happened and if he wasn't given an adequate explanation and wanted to take it further, he should be able to go to the Health Professions Council and I think that is where a professional society can play an important role, because we can review the case and hopefully give an educated opinion on what happened and whether there was wrongdoing or not. I don't think a medical scheme although like I said before, technical is non-profit, is in the business of making a profit, is really the best group to do that and they don't have the expertise to do that.

JUSTICE NGCOBO If they had the expertise to do that?

DR THERON Well the only way they could get their expertise would be by elected members from the cardiac profession in the country, so if there was for example a peer review committee which was independent made up of cardiologists chosen by other cardiologists, respected members of the cardiology community, leaders in the cardiology community, then yes that could be done.

JUSTICE NGCOBO As a specialist whose rooms are in a hospital, is there an expectation that all your patients will be treated from that facility?

DR THERON There are a lot of specialists for example that would work in more than one hospital. One of the main cardiologists at our hospital, works at 2 areas on the East Rand, as well as South Johannesburg, so many specialists do work at more than 1 hospital, so I don't think there is an expectation that you have to treat all your patients there.

For my own practice for example, out of convenience, the hospital I work at, provides all the facilities I need, so I would treat most of my patients there, but occasionally you do need to refer to other centres. For example, we don't have cardiac MRI, so we would then refer the patient to another centre that has cardiac MRC to do those specialized tests.

JUSTICE NGCOBO I am not too sure that I understand the answer. The question is this. Yes you may practice from 5 hospitals, but what I am asking is, is there an expectation that you will treat your patients from the hospitals where you practice from, whether 5 or 6 it doesn't matter. In other words, if you practice from hospital A, can you treat your patients from a hospital with

which you have no relationship whatsoever, despite the fact that those facilities at that hospital are the same at the facilities that you have?

DR THERON I think that boils down to admission privileges if I am correct Dave. I have heard this mentioned before. You can't just go to any hospital where no one knows you and just admit a patient there. You would have to arrange for admission privileges first. I would need to have a meeting with the hospital manager to say look there are occasions that I have a problem, this is what I want to do, this is what I am going to do in your hospital, they would want to see your CV they would maybe want testimonials.

DR KETTELS On the issue of rooms within hospitals, I do believe that practitioners are free. The hospitals wherein those rooms are located, have absolutely no knowledge of which patient has been through the door. There is no tracking of that patients are often in a different part of the building unrelated. Yes the property may belong to the hospital group, but the hospital itself, has no knowledge of what patients are coming through the door as an outpatient.

I do believe that practitioners would be entirely free to choose to admit a patient that they have seen in hospital A to whichever hospital would be most suitable for that patient's further management and that patient's travel needs and I do believe patients would insist on that.

JUSTICE NGCOBO Now when a patient comes to you and then there is a need to admit the patient to a facility, do you discuss with the patient the options? Do you find out from the patient which facility would the patient like to be admitted to?

DR KETTELS I must be honest and say that within my context, I do not have any options available to me, so I can't really comment on that. I would hope that that would be the case, but I cannot answer that question from personal experience.

DR THERON If I can just add to that, also in Johannesburg again, cardiology is quite a specialized thing, so in our area for example, the closest next Cath Lab is probably forty five minutes away and you cannot be that far away. If a patient for example got an arrhythmia which was life threatening, you need to respond immediately, so I don't know if that is a question that is

quite appropriate for us in a way, because we need to be close to the emergencies.

Even if we did have patients admitted at another hospital, you would never admit your so-called hardcore cardiology patients at those hospitals. You would want them close to where you are and that is because of the nature of our profession.

JUSTICE NGCOBO What you are saying is that there is simply no time to discuss these matters with the patient?

DR THERON Well you can discuss it with a patient, but my recommendation to the patient, would be that he or she would be at a hospital where I am resident for most of the day, otherwise there could be a problem and I would not be able to respond quick enough and that could be to their detriment.

JUSTICE NGCOBO Is there anything else that you would like to say in closing?

DR KETTELS No Sir just thank you and the Commission for your time and your kind attention.

DRS VAN GENT Just one small question on a question the Chair raised a couple of minutes ago, that was about ownership of shares by doctors of hospitals and you used the word ethical. It made me think of the ethical rules of the HPCSA preventing you from being on the payroll of doctors. Now we heard submissions of hospital groups that objected to that rule and told us that first of all, it is not unethical, because there are examples of doctors owning shares in hospitals, which might give reason to the same kind of compromise like that allegedly doctors on the payroll could have and secondly, so I would like to have your comments on the ethical aspects of that and your personal views on the applicability of the ethical rules to your situation and whether that is ethical or not and if not, why it is not.

Secondly, hospital groups raised that to our attention because they said it prevents us from organizing the clinical pathways in an efficient manner. I think yesterday we had an example of a patient who said they had a heart scan, there was a suspicion of having heart problems and within an half hour, he had a second heart scan by a second doctor somewhere down the alley in the same hospital. That is an example of inefficiency in the pathway that this patient went through and the hospital group raises attention to this fact and

said we can deliver hospital care much more efficiently, could we control the behavior of medical specialists and align it in the pathway.

DR KETTELS I have no doubt that the independent practitioner model with multiple entities functioning within a single hospital building, will at times, contribute to cost even if it is sometimes as simply as the availability of someone down the passage who can give a second opinion and whether that second opinion is really needed or not, we see on occasions, patients who have been to other doctors, had a perfectly accurate assessment.

The lack for example of an ability in many private health facilities because of this fragmentation that you speak of, for example to share data, to share the x-ray that was done yesterday or the heart scan that was done a few hours ago, these are dreadful costs drivers because of duplication and they speak to the model in which we practice.

I have no doubt that private hospitals would love to be able to change that. Regarding my personal opinion about the ethical rules, I think that where my referral patterns and my clinical decision making would be directly impacted by an arrangement that I have in terms of substantial hospital shareholding, then I would absolutely agree that that for me, would be unethical.

Where there are historical arrangements with miniscule or the most insignificant shareholdings that practitioners have had because in ancient history, this hospital belonged to a different group of doctors and this is the hospital that they have been practicing in for twenty years and it has no impact on their referral patterns, I personally wouldn't see an ethical difficulty with that, but for me to go into an arrangement where my income is directly derived from a decision that I make other than on clinical grounds as to whether to treat a patient, I would agree that that would be unacceptable for me.

DR THERON If I may just add regarding the inefficiency in private healthcare, a large proportion of costs if you go and look at the breakdown, is repeated tests, repeated lab tests, repeated scans. Let me give you an example, the patient will have a blackout, he will present in an emergency department, they will assess him and say he had a blackout they will call the physician who is on call. The physician will come and see him and he will think it is a neurological problem, probably order a scan, maybe an EEG which costs a lot of money.

The physician will then later go and call a cardiologist, he will do a cardiac

assessment, the initial cardiac assessment will be negative. We will say okay it was a onetime episode, let's see how it goes with this patient and see if the symptoms recur. The patient goes off and 6 months later or 3 months later has another event, presents at a different emergency department or even the same emergency department, seen by a different doctor and then what happens is they don't know the history, so they call a different physician and that physician then orders the same tests and the whole process repeats itself until someone picks up on it and does a definitive sort of assessment.

So the way that they can be easily solved, is not by hospitals employing doctors. In fact I think what has happened, we just need to look at what has happened in the US to see what hospitals employing doctors has done. It hasn't led to improved patient care at all, but I do understand that there is a big problem with costs with this kind of thing and when I was working in New Zealand, I worked there for a few years as a registrar as part of my training, they had an Auckland wide system where everything in the patients file was scanned into a central database which we all used to make clinical notes on. If a patient picked up a script anywhere, that would be reflected on that patients file. If a patient had an x-ray, that report would go in there.

When a patient came in at 3:00 am, all you needed to do was first look up that document and you could get the last 6 months investigations that were done, you could read the previous doctor's notes and it really reduced the number of tests that we would do when seeing the patient.

We do a lot of friendly second opinions in our hospital which we don't charge for, because it is your colleague and they are just asking you to have a look at something, so there are a lot of things that could have happened there. We don't know the details.

DRS VAN GENT The fact that medical specialists are not on the payroll, is that an impediment to developing that sort of a system?

DR THERON I think the main obstacle is cost. I think it is extremely expensive to get off the ground initially and you need a lot of support staff because you can imagine all the paperwork that is actually generated that needs to be sorted and then scanned. You need to go to every laboratory in the country, you need to get them linked up on the system and they need to agree to it, there are a lot of role players.

I can't speak for the hospital groups or the medical funders, but my

recommendation to them would be to start small. If we could just get laboratory prescription data and radiology data on a system like that, that would make a huge impact if you look at the cost analysis of private healthcare, a large proportion is laboratory and radiology data, or tests, so if we could just get prescription, radiology and laboratory onto a centralized system like that, it would make a huge impact and those 3 things really help.

DR KETTELS May I say that that suggestion would make a huge positive impact on our practice, within our association of doctors within our hospital and cardiology, we have implemented a similar system. We pay the same service provider to care for our electronic data base records and so after hours, I can log into my colleague if I find that a colleague of mine has seen a patient, I can log in and immediately have full access to their medical file. These IT enhancements would be enormously helpful to our practice.

JUSTICE NGCOBO Does that conclude your presentation?

DR KETTELS It does indeed.

JUSTICE NGCOBO Thank you very much for the presentation and also, for taking time to come and share with us, your experience in these, matters.

DR KETTELS Thank you for your time and thank you to the panelists.

JUSTICE NGCOBO You mentioned the experience in the US where you were referring to doctors working for hospitals, is there a study that you can refer us to which assesses that and can give us a view of what is wrong with the system?

DR THERON There was basically a comparison between GDP of various countries, I think the US comes in 17% which is much higher than any other Western European country and they started doing, where hospital groups started taking over, it is not just a hospital group, it is the hospital group and the medical funder forming a conglomerate and then employing doctors and approximately about I think 70% to 80% of doctors are employed by hospital groups and that leads to more fragmentation.

JUSTICE NGCOBO I think what would be helpful is if you could refer us to specific studies that have been done?

DR THERON We can get that information to you.

JUSTICE NGCOBO Yes and you can submit that to the technical team, thank you. You are from the Society of Private Nurse Practitioners?

MS REGENSBERG That is correct.

JUSTICE NGCOBO Very well, we will run until about 12:50 and then we will break for Lunch. Are you happy with that?

MS REGENSBERG We certainly can do our presentation well within that.

JUSTICE NGCOBO We can start with you after Lunch if you so wish, or we can use whatever time we have now and then break for lunch at 12:50 and then continue thereafter.

MS REGENSBERG In light of the fact that you have probably not had a morning tea break, I think that that decision should be yours.

JUSTICE NGCOBO Please go ahead and if you could just indicate to us how you propose to make your presentation? Who is going to start and so on and also before you speak, if you could just place your name on the record please?

MS REGENSBERG I am Debbie Regensberg, I am currently the Secretary

and National Executive member for the Society of Private Nurse Practitioners. To my left, is Gertrude Nare, she is a member of our national executive and chairperson of our Gauteng branch and to her left, is Anne Berzen who is our national President and the initial presentation will be made my myself on behalf of the Society and all 3 members will be available to respond to any discussion thereafter.

JUSTICE NGCOBO Thank you.

MS REGENSBERG Honorable Judge President, Commission, members of the public, colleagues, thank you for affording us the opportunity to present on behalf of the PNP's who have been supported in the submission by a forum of professional societies. We have introduced ourselves, but may I also comment and say that Anne is an advanced [indistinct 2:49] practitioner, Gertrude is a primary healthcare nurse with a practice in the Berea and I am currently in the education and training world, having been in private practice as a geriatric nurse specialist prior to that.

In our presentation, we are going to start by providing you with a broad overview of the private nurse practitioners as a sector or a group within the nursing sector and then we will respond to the statements or issues.

Let me preface this slide by explaining that nurses in South Africa are registered on 3 levels by the South African Nursing Council. They are professional nurses who have a 4 year basic training plus extensive or at times, no additional specialization and these are the ones that we know as the nursing sisters with the maroon epilates.

Then we have the role nurse or staff nurse who has a 2 year professional qualification and the 1 year vocational qualification which is the nursing assistant. By international definition, a private nurse practitioner can be defined as a professional nurse or midwife and midwife who is registered by the South African Nursing Council and provides nursing care on a fee for service basis and gets reimbursed directly or indirectly by the patient.

While this definition does not include salaried nurses in the different settings that we have mentioned on our slide such as pharmacies, doctor's consulting rooms etcetera, we do find that they also can contribute significantly to the reduction of costs of care and most of the challenges that we face, are also ones that they need to try and resolve.

The services which area provided by the private nurse practitioners, tend be on a consultation basis. Members are available 7 days a week and we do not

work extended shifts, twelve or 6 hours as they do when they are working for nursing agencies. The services may extend from general care of the frail and disabled to advanced nursing care including very advanced wound care, primary healthcare which covers many of the items that are indicated in the second column, as well as various specialist services.

While one would not expect a GP to function at the same level as a medical specialist, an advanced nurse practitioner provides specialist services that are well outside the standard normal set of skills of a general professional nurse. There is an understanding within many of the sectors, that once you are qualified as a nurse, you can do it all. However, the advances in technology and knowledge and the specialized skills, certainly leads to a very delineation between what is an advanced practitioner and a generalist to the extent that the South African Nursing Council has now been given permission to have a specialist register for the first time in this country.

If one looks at the practice models, the practices are constituted across a range of business models, including sole proprietors, partnerships and companies. They may be based in consulting rooms or provide services in a hospital based setting, homes and clinic settings. Many of them, as the

communities would have seen of late in places such as pharmacies, in the past 2 years we have also seen an introduction and a very rapid growth of a franchise type model, such as the Unjani Clinics and the Sharp Left Clinics which are supported by 2 national healthcare related companies.

As indicated in their definition, the reimbursement is on a fee for service basis and it is either directly by the patient or through third party funding. In a survey which we did of PNP's in 2014, it showed us that the geographic distribution was heavily weighted towards the metropolitan areas to the region of almost 90% of private practitioners. In a review of our membership done for the purposes of this hearing last week, there has been a significant growth in private nurse practitioners in the rural areas and regions where we have seen an increase of this group from 4% of our membership, it is now 30% of our membership.

A real challenge facing the nursing profession, is the fact that we are all aging and the age distribution for private nurse practitioners currently it reflects the profile that the South African Nursing Council has of nurses in general where 48% of the current PNP's are over the age of fifty five, 45% are between forty and fifty five and the majority of our practitioners no longer qualify to

work in the public sector because of their age and they have retired, or they have expressed a preference not to return to the hospital environment due to either working conditions or not being able to practice in their chosen field of specialization on the basis that nurses should be able to work wherever they are placed in the hospital.

To illustrate the number of patients that are being seen on average in a month by private nurse practitioners, we randomly selected 4 practices or 4 groups and the data that I have provided, includes visits done in hospital, at homes or in the clinics. They might be providing infant and baby and wound care services such as in the KZN mix practice where there are 3 practitioners servicing those clients.

On an average, these twenty five nurse practitioners are seeing 17 600 patients in a month, or approximately 700 patients each per month. Obviously depending on their type of service this is going to be different. These services show the potential of private nurse practices to compliment the workload in the public clinics and provide affordable services in community settings that are convenient for the patients.

Our fee structure is fluid. As the tariffs originally set by the Board of healthcare funders were set aside by the High Court ruling in 2006, however we do provide our members with an annual guide to tariffs and they are not enforceable, but this is primarily to give them a broad parameter because within the Nursing Council regulations, we can be held accountable for over-charging and yet there is no set fee or no fee guideline.

The lower fee that we have presented here is based on the original 2006 NHRPL, the last legal set of tariffs. However, those were set by the Board of healthcare funders whom we know represent the medical schemes not the practitioners and they decided in terms of scope and value what it was that nurses could charge. It was also based on State salaries for the nurses and would take into account the overhead expenses and costs of running a private practice.

So those are what the private nurse practitioners are, that is what we do. The focus of our submission is to look at the inquiry statement of issues both the original and the subsequent ones and we are not addressing the matters relating to general and frail care, although these are obviously expensive as well in the pockets, because they are not funded through medical aids and

health insurance.

We are going to focus on the provision of primary healthcare and specialist nursing services which would make a much greater contribution towards the containment of private healthcare costs and also improve access to affordable care for the communities, particularly in those areas where State services are either over-burdened or where there are insufficient medical practitioners, or any other healthcare such as in rural areas.

We will be focusing on the regulatory framework, funder constraints and private sector policies. The information which we have, supports these statements of issues that were in the revised set that were published by this Commission in February of this year and really reflects the lack of transparency that limits the informed choices by consumers, as well as the urgent need for a review of the regulatory framework which we believe contains and supports very significant elements which could be seen to restrict competition and certainly limits consumer choice.

The regulatory framework we are presenting from 2 perspectives. In this first slide, we are looking at those which we believe that if these matters were to be addressed, it would enable patients to access appropriate healthcare, while

the next slide we will look at certain legislative constraints which we believe are very restrictive and again, limit access by the public.

Nurses are regulated in terms of the Nursing Act 33 of 2005, as well as its predecessor Act 50 of 1978 which remains relevant as critical regulations to support the 2005 Act has still not been finalized where we are now sitting 10 years later. In terms of the scope of practice or that what nurses may do legally, the Nursing Act does allow for authorization of professional nurses with additional skills, to provide primary healthcare services including the diagnosis, treatment and prescribing of medication according to established guidelines.

In conjunction with this, the Medicines and Related Substances Act allows suitably qualified professionals to obtain dispensing licenses to provide such medicines to their patients. However, we find that the interpretation of the legislation as well as the lack of the appropriate supporting regulations that have not yet been passed, has resulted in the licensing of officials at the Department of Health coming to a summary decision to exclude all private practitioners if they are not offering occupational health nursing services.

At this stage, we have been unable to establish what progress is being made in regard to getting these missing regulations through the system and it continues to be an impediment and probably accounts for 60% of the inquiries which we receive from members or potential private nurse practitioners clinic systems, saying when I worked until last month for the State, I was authorized, I was allowed to dispense and prescribe, but the day that I resigned, I lost my license, I am not longer deemed fit. It is this that we are urgently looking to address.

On the restrictive side, we have a regulation, there is very limited access to information and services and in the most recent regulations published by the South African Nursing Council on the Act's for which the Council may take disciplinary steps, the new regulation substantively prohibits nurses or the employers or agents from making their services known in any way whatsoever.

Requests for meetings with the Nursing Council have been to clarify the intention behind this regulation, have been unsuccessful. Consequently, if nurses abide by this regulation, or the employer abide by this regulation, patients and consumers, as well as other healthcare practitioners, would have

absolutely no way of identifying or contacting appropriate practitioners and particularly those with the key specializations required.

It is also interesting that nursing is the only healthcare profession in South Africa with this type of restriction of making known their services to advertise. All other healthcare professionals and their professional councils do allow a limited level of advertising and sharing of this knowledge.

The second constraint which we have is that of restriction on partnerships. While this regulation states that nurses may only be in partnership with other nurses, we know that the ethical rules of the HPCSA has a similar restriction, where they may only be partners with other members who are registered within the HPCSA. Nurses therefore are allowed to be everyone's employees, but we may not be partners within a multidisciplinary practice.

Other professional councils restrict them being employees of nurses. For example, if one now wishes to establish a patient service which is a comprehensive expert diabetic practice, it has to by law, or by ethical rule, exclude having a nurse, a pharmacist or a social worker as a member of that multidisciplinary team, although they may be employees in some instances.

If we move forward to the funder constraints, there is no mechanism and that was referred to by the previous presentation as well, there is no mechanism to generate new or additional codes for nursing procedures for the purposes of patients submitting claims to medical schemes and particularly, given that these previously authorized procedures were authorized by the Board of healthcare funders, bearing in mind that the BHF represents the funders and not the patient needs.

We have attempted to establish who has the authority to generate such codes and of course that is the major conundrum today. Neither the Board of healthcare funders, nor the Council for Medical Schemes has this within their remit. They repeatedly refer us to the South African Nursing Council who refer us back to ourselves, because they are not part of the system of funding and reimbursement and it is also outside their remit.

So occasionally a scheme will generate a code for a particular procedure on a day, but these are not standardized across the schemes and some of the codes that we have been requesting since well before 2006, but certainly since this restriction on the BHF function to general tariffs which is linked to the codes, have included such things as HIV treatment, management of sexually

transmitted infections, diabetic education where the diabetic nurse specialist is the key person to start a new patient on insulin therapy, assisting mothers to promote breast feeding by specialist lactation consultants, contraceptive services, intrauterine devices for contraception and lymphedema drainage. The list is much more extensive, but we have chosen to highlight these.

What is interesting is that many of these treatments fall within the ambit of prescribed minimum benefits, but because they are not necessarily hospital based other than lactation consulting and the diabetic education, they are deemed by the medical schemes to be excluded because it is not part of hospitalization and after all, the hospital is reimbursed for all nursing services and this cost is having to be borne by the patient or bills raised by the private nurse practitioners are ignored.

While most funders will extend nursing benefits out of hospital, because they recognize the role of nurse practitioners to keep patients out of hospital, prevent readmissions, it is normally left to the discretion of a case manager and one will be given authorization to attend the patient in or out of hospital, but subsequent to the authorization and often even after payment, the payment is reversed, leaving the patient responsible for the fee and the nurse out of

pocket.

We have chosen a case study of a particularly difficult case, but this was not unique, of an unresolved transaction between a medical aid, a private hospital group and an advanced wound care practitioner, which we have been dealing with for the past 2 or 3 years without any success

The guideline on your screen demonstrates part of the complexity of the decision making that goes into basic wound care and wound healing. So one would ask quite rightly why would one need to call in a private nurse practitioner when the hospital is actually being paid and should be providing all the nursing care. In the revised statement of issues, the claim has been made that there is a dramatic increase in hospital based claims and this is driven in significant part by the nursing salary increases.

To come to this, the majority of the private hospitals and public hospitals have reduced or eliminated all the advanced clinical nursing level positions, mainly for budgetary reasons. However, it is impossible for a generalist nurse to keep up-to-date with the rapid advances in knowledge and technology.

At the end of the day, the patient still requires the technology and the services to improve their outcomes, to reduce the hospitalization time, prevent readmissions and allow for recovery in a home setting, thereby reducing the risks that are often associated with hospital required conditions.

In this particular instance, in the case study, this is an extract which I will not read, as the Commission has this as an additional submission, the scheme decided on review of this practitioner to do what they term a negative cost adjustment. In other words, claim back the fees which had been for all the services she had provided over the period of 2 years for various patients while patients were in hospital. We note that in the original submission of the South African Physiotherapy Society, they referred and included a document that they entitled the Healthcare Practitioner's Extortion by Medical Aid Schemes Unlawful.

While this situation is not 100% identical, there are sufficient similarities for us to believe that this is coercive on the part of the schemes and the hospitals. They further referred the practitioner in the third paragraph to the physician or the hospital manager as the schemes believe that the hospitals should be responsible for the nursing fee. We don't dispute that. They then go on to

inform the practitioner that patients not be requested to pay for the services, as this would constitute duplicate billing and subsequently threatened her with reporting her for fraud and similar kinds of unethical and unprofessional behavior.

The hospitals response was to advise the patients and the medical practitioners that private nurse practitioners are not entitled to claim for tariff for the services rendered, but there is an exception being stomal therapists. The reality is that medical practitioners request advance nursing services. We also know that medical practitioners will often keep patients in intensive care for a much longer period than required, because of the number of nurses or greater expertise available.

Very often, these private practitioners are working after hours or at weekends going to theatre with the surgeons to assist in wound dressings in both theatre and wards, because the hospital staff do not have the necessary advanced skills.

Funders and hospital management restrict funding, although service is not provided by the hospital in most instances, although we are now starting to see some instances where one of the hospital groups is remunerating the

private practitioner if one has been through an extensive authorization process per client.

In a further scenario, patients may also not be seen by their own practitioner while in hospital due to this policy, unless it is done as a free visit. This is exacerbated by the reluctance of ward staff to allow nursing care plans or recommendations to fund the advanced practitioners to be considered or implemented, even though they don't have the skills or maybe knowledge of that particular patient.

Another area, in which the private sector policies have a significant impact, is that of indemnity insurance. We know that the extremely high caesarian section rated in the private sector in South Africa at the level of 70% to 80% of births, is 3 to 4 times higher than the international norms. Indemnity insurance has been identified as a key cost driver in influencing this practice and women are therefore pressurized to accept caesarian sections as the norm for a range of reasons in the private sector, but it includes the high cost of professional indemnity for obstetricians, as well as very limited indemnity available to midwives with no indemnity insurance being available at all for

doing home births.

However, midwives have restricted access to obstetric units in both the public and the private sector and very often obstetricians are willing to provide the back-up required by the midwives who have limited hospital admission privileges.

While the midwife assisted birth with the properly evaluated patient is not high risk, women have been giving birth since time immemorial, giving birth in a hospital setting with the same day discharge rather than at home, obviously is safer in the event of unexpected complications.

We have fewer than 5 private midwives obstetric units in the various cities, but generally there is a restriction on access to hospital facilities for midwives to assist their ladies who are giving birth and therefore, mothers have a choice between a caesarean section by an obstetrician or a home birth with a slightly increased risk.

We believe that this certainly is a major contributor to many of the costs which we know the medical aid schemes constantly complain of. Finally, there are nurses with legal authority as not recognized by others in many

settings. Where nurses have been authorized to prescribe or dispense medicines, there is a refusal by pharmacists supported by their professional society, to recognize such prescriptions and then in another instance, the majority of employers do not accept sick certificates issued by nurses, even those with authority to diagnose and treat the conditions in primary healthcare settings who are very skilled at making this decision.

Patients therefore incur significant additional costs of having to see a GP, further absenteeism from work and many additional out of pocket costs. The international evidence is clear in many instances that having access to advanced nursing practice, practitioners also play an essential role in the care coordination and transition of care that results in reduced hospital length of stay, fewer hospital admissions and hospital acquired conditions.

Most funders do recognize it, yet they will not fund specialist in-hospital care requirements. The professional authorities and bodies and health authorities do not provide a framework which encourages multidisciplinary collaborative care models in the private sector.

In conclusion, we strongly believe that nursing services can contribute significantly to the reduction of hospitalization costs, access to affordable

community based healthcare. It will however require an acceleration of the development or issuing and completion of the regulatory framework and particularly, those relating to authorization licensing and advertising, as well as the inclusion of critical nursing practices within the PMB frameworks.

On behalf of my colleagues and myself we thank you.

JUSTICE NGCOBO The time now is 12:50. I wonder if it would be appropriate at this stage to take the Lunch break and then we will come back at 1:30.

[END OF FIRST SESSION]

[START OF LAST SESSION]

JUSTICE NGCOBO Okay, very well, thank you. Are there any questions?

MR SELEKA Yes, Judge, just a few.. Hi Debbie, thank you for the presentation. If you could, you know, briefly just educate us about the private nurses. I know in my life, I have encountered a mid-wife, but I wasn't sure whether they were private nurses, as well. Are you as PNP, Private Nurse Practitioners, qualified equally as the other nurses, employed in public or private hospitals? Do you receive the same training, the same qualification? .

DEBBIE REGENSBERG One can be a professional nurse or nursing sister without having midwife qualification, but since 1984 all professional nurses also have midwife as a qualification. Not all nurses will practice as midwifes, though. So, we currently have very few midwifes who are in private practice in South Africa. But all the, the majority mid-wife's in South Africa are professional nurses. And in terms of the training, the training is absolutely identical. Most of our members were trained originally when working within the public sector, or have paid for their additional specialized trainings, subsequent to that.

MR SELEKA So, as private nurses, where do you operate from?

DEBBIE REGENSBERG If I take my two colleagues here as an example, Ann has rooms close by one of the private hospitals. She sees patients in her clinic, at her rooms. She will also see them occasionally in her home, in their homes, although that obviously has time and financial implications. And then she will see patients in hospital, at the request of either the surgeon or medical device company or the ward staff will call her in to provide the advanced care. Getrude operates from one of the primary health care clinics up here in Gauteng. One of the [Umjane] clinics, so she will

practise from here consulting room and the patients there tend to be walk in or know locally that here is a primary health care clinic.

MR SELEKA So, in respect of Getrude, the facilities from where she practices, is this all privately funded?

JUSTICE NGCOBO I did not get the question?

MR SELEKA The facilities from which she practises are they privately funded?

DEBBIE REGENSBERG Yes, they are privately funded.

MR SELEKA So how do you – what is the relationship between private nurses and private practitioners, for instance, either in the public or private sector? Can you refer patients to them, what is the relationship there?

GERTRUDE NANE Because we are made of different disciplines, you know, for Ann who is in wound care, if her patient comes to me, obviously that area of care requires specialised wound care. I will then refer, so we will refer amongst ourselves, as a first _line intervention, then should there be a need for further referral, then that takes place at that point.

MR SELEKA The further referral, then it goes where?

JUSTICE NGCOBO Can I understand, as I understand what you have told us, is this: sometimes they are referred to you by medical practitioners, to continue with your treatment after hospitalisation, there is a treatment from home. You operate rooms privately; some of you are attached to pharmacists.

DEBBIE REGENSBERG That is correct, all patients will self-refer, particularly when one is looking at the frail, aged, but in terms of the referral, we will also refer to other disciplines, be that [podiatrists, surgeons, back to the general practitioner, so we work as a collaborative team.

MR SELEKA So, in that collaboration, can you explain – you gave two examples in your presentation, that your fees are either directly paid by patient, or indirectly paid. What do you mean by indirectly paid?

DEBBIE REGENSBERG There is a range of nursing services for which medical schemes will reimburse for nursing services. They will not reimburse for services if the patient is currently in hospital, even if one requires the advanced health care service. However they will reimburse according to their lists of services. For example, I can go

take my child for his immunisation to a private nurse practitioner, and there will reimbursement. But if I want to go and get my contraception from a private nurse practitioner, there is no nursing consultation that allows for family planning currently. And so the patient then needs to either go to hospital, or go to a private doctor or clinic. So that would be the indirect as when the medical aid reimburses, directly, is where the patients are responsible for their accounts. And that is in the instance where a patient is in hospital, the doctor calls the nurse in to provide specialist care and the medical scheme refuses to pay. And then obviously those patients without medical aids, and a practice, such as Gertrude's which operates as a cash practice. Patients will pay out of pocket and will then attempt to get reimbursed from medical schemes. So the patients have expenses in terms of nursing care costs, because medical aids don't pay that.

ANNE BERGEN I think that the thing that we need to know is that medical funders, view nursing as coming out of a patients' savings, they won't fund nursing out of major risk, so the patients' savings become depleted and then there is no cost care available to cover. So it just depends on which plan they are on and how much cover they have got and usually by about March, people run out of money to pay for nursing costs. So, they will pick a clinic and stuff, and that fee will fall on themselves. Sometimes where we put a motivate under a PMB condition, but on an average that PMB condition is not recognised, cause it is a nurse who is giving the

service. So it is a big – it is a fight, it is not a 'you will try the nurse first, and then you go the next day and say, the nurse was the last resort'. When we have specialized skills, we can really make a big difference and turn that around.

MR SELEKA Are you aware of any regulations that govern your profession?

JUSTICE NGCOBO As private practitioner or as nurses in general?

MR SELEKA As private nurse practitioners?

DEBBIE REGENSBERG The nursing act that governs us, has in one of its requirements, is that the minister shall make regulations regarding private practice. Those were the missing regulations that I was alluding to, and so, in the absence of this specific private practice regulation, and the absence of the certificate of need, the nursing council has inserted about six or seven clauses into a regulation called the acts or omissions for which nurses may be disciplined by the South African Nursing Council. And it is within those regulations, that they then refer to advertising, taunting, perverse incentives, although they don't call them perverse incentives, they talk about financial benefits. And then with whom one may go into practice. What we are looking for, and what we believe is essential, is that there is an appropriate set of regulations or

ethical guidelines for nurses wishing to be in private practice. Because I think the patients need to be protected from those who are doing it as a moonlighted hobby as oppose to those who are skilled and offering a well-qualified expert nursing service or be it on a very low level of care or a very high level of intervention.

PROF FONN Sorry, just for clarity, this is noted as 660 of 2012, that you included in our pack?

DEBBIE REGENSBERG That is correct.

MR SELEKA If the regulations were to be met, would you – would it be your desire, to have those regulations deal with the setting of tariffs by the private nurses? Or should that be left to the profession to determine?

DEBBIE REGENSBERG I am hesitant to answer very directly here, because I think that our experience is that the, who defines who within the profession sets those tariffs. And if one looks at the current constitution of the South African Nursing Council, there is nobody serving on the South African Nursing Council, who is in private practice. There are two or three members of the council who are working in the private health sector, primarily, in fact for private hospital groups. I think that what we needing to find, for setting of tariffs is a correctly mediated or negotiated mechanism,

that is not driven purely and decided on by the board of health care funders who are the representatives of the funders. As has been in the past, I think there needs to be more open, transparent mechanism with a fee setting committee that takes into account, overhead expenses, hours that are worked, no different to any of the other health professions. I don't think that it is peculiar to the nursing profession. There needs to be a mechanism of a range of tariffs, but not regulated by one of the players.

ADV PILLAY (SC) I just have one quick question; You will note that one of the issues with is identified in the revised statement of issues, is the question of whether the dramatic increase in hospital based claims, can be significantly attributed to the increase in nurses' salaries. I think you deal with this in slide 19, of your presentation. Now what we don't see in slide 19 is whether you in fact dispute or acknowledge that as a fact.

DEBBIE REGENSBURG I think that we would be foolish without spending a reasonable amount of time analysing the accounts of the private hospitals. I don't believe that – I do believe that nursing certainly contribute significantly to their costs. What we are seeing is, over the last five to ten years, most of the private hospital settings, what they have done is, reduce their permanent staff down to a coreand utilizing agency staff to top up according to patient acuity levels. As a results of which

you are getting a lot of part time staff coming into wards, who don't have knowledge and skills of the technologies of the material available of the services required by that particular medical practitioner, or that the patient needs. And I think that one may see an impact of the recent changes to the labour regulations, where any temporary employee, who has been in the post for more than three months, is now entitled to all the same benefits as a permanent employee. And whether that is going to influence this current trend, where the hospitals utilize minimum own staff and maximise their staff with agencies,I think that is more for the accountants and actuaries to work on we – it's an opinion on my part. It's not an educated answer.

ADV PILLAY(SC) Thank you.

ANN BERZEN Thank you. I think if I can just add to that, we did find, with that same thing, that the major hospitals have reduced their skills set amongst their nurses. So, where an advance wound care practitioner or a diabetic nurse educator, or a breast feeding consultant, were permanent employees at the hospital previously, they have lost their jobs and were supposed to be functioning in that setting then as a outside consultant. And that is where our problems come in and where the funders are now denying us access, saying 'no no no that's okay, the hospital has been paid for nursing and they can cover all those nursing costs'. But the first thing that got chopped was

anybody with an advanced skill set who was practising independently in that facility. So, that fell away, and now that gap is not been filled, so I have a patient, just to be gory at the moment, who has a really bad disgusting, huge wound and the nurses are all going: ah, we can't be expected to manage that and the ventilator, and the lines, and his leukaemia and his, call a wound nurse, and the wound nurse is going, 'the medical aid is not going to pay me, sorry, folks, I am not coming in'. And then the patient ends up being responsible and the hospitals are having to negotiate a fee for me to go in, cause I would love to give my time for free, unfortunately I have some costs and things I need to recover, I don't mean to sound as though I am totally money driven, but I have seen so many patients for them for free, to become in involved in a situation like that, I have to say no. And so when you ask whether or not the cost of nursing have driven the hospitals, nurses have to be paid the living wage.

ADV PILLAY(SC) Can I just ask, in the scenario that you have given, is there any contractual relationship between the hospital and the wound nurse, a direct contractual relationship?

ANN BERZEN Denied by the hospital management, until the nursing staff put their foot down and said 'we are not doing this, you must allow her in'. And then a loose contract has been informed at the moment, and hopefully we will be able

to establish that into something more, in some of the rural areas, for example, I am from Cape Town, so Worcester, for example, their private hospital has contracted to the wound nurses, rather than having them employed. The hospital is too small to warrant the cost of that, and at the end of the month, they are able to then pay that. It will have to be on an individual hospital basis, that it would make sense to them to recover that, the funders are refusing to cover.

PROF FONN Thanks very much for your presentation. I am curious to understand something that confuses me. Are you – you tell us that your interventions would be cheaper, for example, seems to me in some cases you could replace doctors, or you fill a gap where there are no doctors, for primary care diagnosis and treatment, you can decrease hospital stay, because wounds can be done at home. So this seems to be cost saving, and yet, the medical schemes are not interested in this. And this seems to me, to make no sense. So, how do you explain that, why would they not be interested in something that is cost saving for them?

DEBBIE REGENSBERG I would certainly not say that the medical aids are not interested. We are working with two of the large administrators at the moment. Putting together, they have been working on managed home-based care programs. The biggest problem that we have there is that while we have within our society, we have – we

represent, just short on two hundred and fifty private practitioners around the country. The one scheme launched their program late last year, very aggressively. And found then they didn't necessarily have nurses in all the areas. And on the one hand, but on the other hand they were so overrun, that they could not cope with the work load and it almost it has imploded, and they are now trying to resurrect it. So the schemes are aware. However it comes back to the referral pathways, if my patient – I have my GP with whom I'm working, admit a patient to hospital, if the scheme takes over on managed care, I possibly won't get my patient back. My patient will be given to another nurse, who is authorized, and the patients don't want to have to change. And the medical scheme says but I am only authorizing that practitioner, because I might not be part of their particular group or contracted to the medical aid.

So, there is a move, that's why I did not deal extensively in our presentation with that element. There is move, definitely, from the schemes to look at that early discharge. The problem arises primarily with the midwifery costs, with the primary health care costs, the lack of tariffs, where in primary health care, nationally we don't have enough doctors. Our nurses in private practice are the same nurses who, until a year or two years ago. We are working in a state sector without medical supervision. Going back to rural towns, places like Sutherland, where a client, where a nurse – she is the only

nurse in the town, until mid-last year, she worked for the city, for the municipality, but she now is no longer competent to have a dispensing license.

PROF FONN I understand the technicality in the public sector is that normally nurses are under the direction of doctors, which is why they can dispense, whether they are in practice or not but normally, they are. I got two other issues I wanted to explore with you. Who do you think is either – why isn't the nursing council, for example, representing your interests? Why wouldn't – I suppose what I am trying to find out is when we speak to other players, what kind of question we should be trying to understand better. Why is it in their interest not to, for example, form a lobby group to create the codes, seems to me that many people create codes, seems to be a free for all, at present, why wouldn't they do that. And then related to that, who and – who is stopping regulations coming through, and why would they be stopping those regulations coming through?

DEBBIE REGENSBERG May I, respectfully ask that when the commission meets with the nursing council later this week, or I think during the Cape Town week, that that second question be addressed to them. It is to our intense frustration that the regulations are not being generated or the inappropriate regulations that werepublished as draft in 2008 and 2009, have still seen not the light of day. And practise has changed

since then, so respectfully, we won't be answering that question.

Your first question, however, one needs to bear in mind that the nursing council's role and function is the statuary control and regulation of the nursing profession. They are not involved in what they would be equating. A salary negotiations, because, effectively, the funding is about how do we generate and earn an income. We see their role as licensing us to practice. Whereas our challenge here, is the whole issue about, whose responsibility is it to argue for appropriate tariffs, to decide which procedures are appropriate, within the licence that has been given. And, I think that it – there has to be a central tariff committee. But it also has to be done in such a way that all the stakeholders, including the consumer, actually get an opportunity to participate in it.

PROF FONN And then the last thing that I don't know is in your brief, but the nurses that work for – who come in, say, to theatre, to support particular equipment, a prosthesis, or something, are these people part of your organisation, or is that a separate, and then I should not ask any questions.

DEBBIE REGENSBERG It is a very pertinent question, and I am not sure whether [SAMED] will be addressing some of that when they do their submission. At the moment there is a lot of discussion between the hospital groups, the funders, ourselves and [SAMED], as representative of that groups. And there are effectively three

categories, where that person going into theatre, is a medical representative. It's very clear their salary, they are part of that provider company and they are there to ensure that that equipment is complete. Then there is the nurse who is employed by the company, but is not out there to generate sales. They are there in a role to educate and support and assist. And they are sitting in a grey area in the moment, because of the actual admissions, if they pushing their product, it's a perverse incentive, is it in the best interest of the patient? Are they allowed to touch the patient in the surgeon, because the rep may not touch the patient. And so, practitioners like Ann, will be requested by companies, to go in, because the doctor has already requested the product X, or particular brand, and she will go and assist the surgeon.

PROF FONN So who pays that person?

DEBBIE REGENSBERG At the moment it is an area that is under intense negotiation because of this regulation. In some instances, the cost of that nurse is included in the product and the product provider then pays the nurse. What it should be, in terms of the acts or omissions, is that the patient or the funder should be paying the nurse directly. It should not be coming from the product supplier. But at the moment, because the medical schemes will not reimburse, the only way in which we can ensure that the patient is getting the best possible assistance, is to go through that

route.

PROF FONN And do you believe that this practise has any influence – I mean, one of the big – one of the issues that have been put before us, is that the equipment is incredibly expensive, technologies and so on. Is including the cost of the nurse in the product legitimate and is it pushing up the cost of the product?

ANN BERZEN I think I need to say that it is not just going into theatre; it's for example, a diabetic nurse educator who is employed by an insulin producing company. The doctor prescribes insulin, that nurse is then dispatched to go and teach that patient how to administer that, and then those costs are funded by the insulin company, because that diabetic nurse educator, under the current structure can't get paid for her service. So, I mean, its, do help us, but God, don't use your hands. It is really difficult to say don't do that, you know, a company will employ a specialist [indistinct 0:28:48.9] nurse, because she likes – and because she is employed by that company, she's got to go and mark the patient, prep the patient for the day, recommend a bag, but of course that is going to come from her, the company that is going to pay her for that consultation. So, it becomes a very grey area, and it is not just with a wound care or a device, it's how do you create – how is this law, and our act going to be facilitated, is really the big question. At the moment we don't get the answers from

our regulatory body, and that's where we sitting at the moment.

DEBBIE REGENSBERG I think, coming back to your question, yes there is a certain potential for a cost reduction of medical devices if there was a legitimate way in which to reimburse the nurses fairly. But when the medical aid rate for a nursing visit, for under fifteen minutes, is currenlty sitting at R75.00seventy five rand and for fifteen to thirty minutes, is a R160.00.. You cannot earn a living, raise a family, and cover your practice expenses and cover the costs of incidental equipment on those kind of tariffs.

JUSTICE NGCOBO One of the submissions, made by the hospital crew, tells us that there is shortage of nurses in South Africa. Secondly, that the salaries of the nurses in the public sector are higher and that the private sector has to compete to get those nurses to come and work for them. That is one of the reasons that drives the costs of private healthcare services An issue which are further told is complicated by its huge demand for South African nurses internationally. Comment on that.

DEBBIE REGENSBURG Chief Justice, I don't know that my colleagues, or I have analysed the information to that extend. I know that our private hospital groups are – the three major ones are bringing in nurses from other countries to supplement and address the shortage. There is definitely a shortage of nursing skills in this country. But

we also know that many of these skills, advance skills, these practitioners were in fulltime employment in hospitals. And over the last five years or so, have been let go, because the hospitals feel that they can't be fully utilized. But I think more – and yes, the public sector salaries are greater than the, possibly some of the private sector groups. But the private sector are also using nursing agencies extensively, and that adds a whole another layer to the cost of staffing to increase and have sufficient man power available, because they have a strategy of minimal permanent staff and top up using agencies. But your agencies' cost is adding probably another forty percent to the cost of the nursing. So is it really more expensive than employing their own staff? And I think the other fear, of course, which we raise, is the fact that we are an aging group of professionals. And very few nurses are coming up through the ranks, and those that are, aren't staying in the industry because of working conditions, because of poor salaries.

JUSTICE NGCOBO May I understand, the point you made, I men, as a lay person, when I go to hospital, for example, and I require nursing services, I mean ordinarily I would expect that the hospital would provide those. Now, under what circumstance does it happen that the hospital will be required to bring in outside assistance to provide the nursing services which they should ordinarily provide as part of the service?

DEBBIE REGENSBERG I think the example that Ann gave earlier, where she currently has a patient, who is being referred to her with a very gross wound as a result of infection, the patient is in intensive care, has got intravenous infusion, is being ventilated, is getting very high level of care from the intensive care nurses, however, their skills set, while they are very comfortable with the basic, uncomplicated wound, there skillset doesn't extend to this really complex, very gross wound. And so, in that instance, Ann has been called in to provide the assistance. A ward nurse, by enlarge, because of the different technical requirements, the variations between the different insulins, for example, and the insulin pens which are used to administer, the ward nurse is very competent in providing the twenty-four-hour basic care.

But she does not have that necessary insights and skills to understand that when that patient goes home from hospital, because she is trained and works in a hospital environment, she doesn't have the insight to know that when that patient goes home, the patient can't get out bed, doesn't know how to cook, and therefore lives on Kentucky fried chicken, or equivalent, Nando's, I don't push to raise any particular brands. But they buy out food which doesn't equate with the diet they had in hospital. It is not just about how to put, to start the insulin, it's about how to cope with this new disease when they get home. And then follow them up, when they get to the home setting.

JUSTICE NGCOBO Does it come down to a lack of expertise, a lack of skills?

ANNE BERZEN Mr Judge, if I just can say, I mean, I worked – I had the great pleasure of working on cruise ships, international cruise ships for a few years, the one thing I learned, is when the staff are happy, the clients are happy. Now, when you are in a hospital, and you have a nurse who is coming on, and she has worked a double shift in another hospital, and now is moonlighting there, because she is an agency nurse who is trying to cover her basics, it's the setting that she is in. She is not going to give you the care you need, and there is no buying from her, she doesn't need to look after you. Your attention or return is not important to her.

When your quality and quantity start to become a problem. If you don't look after you basic staff adequately, and train staff sufficiently, and allow them a future. I go into an intensive care unit, and I will see nurses who been in there for fifteen and twenty years. I am sorry, I am an ICU qualified nurse, I, straight up, I tell you that, twelve hours, on your feet, in a no-thanks-environment where you fight every minute of the day for somebody's life, becomes a real issue. There is no – they don't – I do feel the staff attention, and the staff – the staff are unhappy, because they don't get given the opportunity of being part of the process of – when you walk on a cruise ship,

everybody smiles, how are you, welcome, let's make this a good event for you. We are going to work really hard at make sure you do well. The nursing staff are – oh God, here we go again. And I really find that that's part of the problem. I don't know if they are obtaining the quality staff that they need. And maybe that might be something that they need to address.

JUSTICE NGCOBO Some of the hospital crew have complained that they are limited in terms of how many nurses they can train, I think the figure is about three thousand, I think it is that was given. And if they were allowed to train more, they will increase the number of nurses. Do you accept that?

DEBBIE REGENSBERG There is certainly, in terms of the basic training, in getting more people to come into the profession. We know that the nursing colleges, both public and private, are severely restricted in terms of the numbers of students they can take, either by the requirements of the higher education and training department or by the South African Nursing Council, because you have to have sufficient clinical sites for them to do their practical. It is not just a classroom exercise. But I think that what Ann is eluding to is, once a nurse has qualified, what career progression have they got? Are there additional training options for them? How does one keep them motivated? If you are feeding the patients' soul, seven days out of every fourteen on

twelve hour shifts, who's feeding your soul occasionally? And that's really that burn out. And then those nurses are moonlighting in their off duty times, instead of going for continuing professional development, looking after themselves. So the whole nursing experience needs to be re explored. The minister of health did have the nursing conference and exploration a few years ago. But I am not sure that those matters that were raised have been addressed and the nursing industry globally, is suffering from many of the same problems that we having in South Africa, it is not all unique to us.

JUSTICE NGCOBO Thank you.

PROF FONN I suppose one of the questions that must be asked is; this is a new environment, and you choose to work in a private sector, and so there are challenges, and you need to be innovative and deal with them. And what we have to understand is are there competition related barriers to your entry. Because if it is a case that you simply aren't organised enough or innovative for whatever it is to what one needs to do to make it as a private practitioner, that's not our concern. Our concern is, are there structural barriers, so I understand that you said that the one structural barrier is the confusion around regulation, and that is the one structural barrier. There also seems to be an issue around coding, and that seems to be another barrier, but that might be solved by innovation, by yourselves, I don't know. Are there other barriers, and if it

cannot be solved by yourselves, the issue around coding, then please bring that to our attention.

DEBBIE REGENSBERG The issues around coding, we have approached the council for medical schemes, we have approached the BHF and we know we are not the only professional group with that challenge. And we are pinning our hopes on this commission to make recommendations to resolve it for the industry because I don't believe it is appropriate to try and do it on a piece meal basis, that is causing more problems than it will ever solve, because each scheme generates its own codes and then the client won't share the new code with anybody else. In terms of the actual competitive issues, the regulation relating to advertising or making services known to patients, giving consumer choice, is a major critical issue for us.

The regulatory framework is a major and all of these – we have had to take quite drastic steps to get meetings with certain of the authorities, and fifteen months down the line, it is still not managed to get a single meeting with the South African Nursing Council. And we cannot get reasons for that. So, I think that our regulatory framework and the refusal by the authorities, is the key issue. I don't believe that our members, private practitioners are not innovative. There are some fantastic practises and systems and I really would like Gertrude to comment on that. I think that it comes down to the

regulation around advertising, the coding issues, and in particularly the multi discipline practise issue, where between the HPCSA and the nursing council, and this refusal that says, but you are separate council, you cannot be partners. But the doctor, physio and a phychologist, etcetera can have a group practice. But it must exclude a nurse, and it must exclude the pharmacist.

GERTRUDE NANE I think just to add, you know what impact it has on the patient, we sort of, not, you know, mention the impact on the patient. Because in my environment, in my model for primary health care, I'm giving a patient a choice for an alternative service. I happen to be located not far from our public facilities and specialised doctors, but from a public facility, because they close early, they cut off their ques, say, in the afternoon. I am that alternative back up, I mean, the figures that have been presented over fifteen thousand patients that I am seeing per month, show that there is actually an alleviation of the burden from the state.

If those fifteen thousand patients that actually were to have gone to a public facility as much as the staff is perceived to be earning more, they also get burn out based on the volumes that they are seeing. So, we looking at a way in which we will be recognize in partner to be a vehicle that provides service or alternative service. And to try and reduce the cost and alleviate the burden of costs, especially on the state facilities, and

also giving the patient an extra choice to go for, you know, the service of their choice – service provider of their choice.

JUSTICE NGCOBO Yes, very well. Is there anything that you would like to draw to our attention which you have not mentioned?

DEBBIE REGENSBERG Your honour, I think at this point, we have raised those which we believe are relevant to this commission, there are a number of other issues, but it is not for this particularly hearing. Thank you very much for the opportunity.

JUSTICE NGCOBO Yes, very well. Thank you for coming to make the presentation, which was quite informative, and thank you so much for taking time to be here. Thank you very much. Thank you. Good afternoon, gentlemen, is this COSATU?

MR KGARA Yes, it is.

JUSTICE NGCOBO Could you perhaps indicate to us how you would want to structure your presentation?

MR KGARA Okay, thanks Judge. Well, essentially, our presentation is a summary of our earlier submission, and simply we will read out a statement.

JUSTICE NGCOBO Which earlier submission? The one that you – which was in response to call for submission?

MR KGARA Yes, okay. Shall I go ahead?

JUDGE NGCOBE If you would place your name on record, please and then you can go ahead, thank you.

MR KGARA Okay, I will introduce myself and my comrades will introduce themselves. My name is Sydney Kgara, and I am coming from COSATU.

MR MORALO My name is Tshegofatso Moralo, also from COSATU.

MR MAVUSO I am [December] Mavuso.

MR KGARA We are here from NEHAWU, a leading health union, but it's an even bigger honour to make this presentation because we are representing and speaking on behalf of the one point nine million strong membership of COSATU. So this submission, while is pioneered by NEHAWU , is actually a COSATU submission, so I want that to be understood.

Many of these workers, especially those who are employed by private sector, do not have any medical insurance, but still those who may be medical scheme members come from households for which they are responsible for their welfare, that do not have any kind of medical insurance. Therefore we are giving expression to concerns of the broader sections of the working class and the poor.

Nonetheless, our motivation in this exercise is that we believe that many of our members who are members of medical schemes, are part of the population that are on the receiving end of price gorging and rand seeking that is prevalent across the value chain of the private health industry. We have welcomed the establishment of the health market enquiry, even though we are concerned as to the implications of its outcomes, given that fact that this takes place under the auspices of the Competition Commission. In part this is because, in our view, the 2004 ruling, in collective bargaining between providers and schemes, may have arguably exacerbated the rise in private health costs, and it appears as if this issue would not even be under consideration in terms of the revised statement of the issues.

In this input, we do not rehearse some of the points made in our original submission, instead we deal with some of the key points, and in the process we simultaneously respond to some of what is in the revised statement. So we would like to deal with the

context of this enquiry. It is never [indistinct 50:51.8] to state the odds that our approach to the enquiry into the higher private sector health [indistinct 50:57.7] is informed by our starting point that health insurance is a critical component of social security within an even larger context of comprehensive social security. It is therefore not yet another business sector for profit maximisation.

It is our understanding that despite the advances that have been made towards the direction of the comprehensive social security in South Africa since 1994, in the overall, the reforms that have taken place have been at best, a patch work of peace meal and disjointed efforts that could be best described as parametric. In other words, these reforms efforts, these reforming efforts, have largely been tinkering with what has been inherited from Apartheid, with a view to expand access within a model that is largely suitable for a highly racialize and unequal order. Hence the outcome of the past dependency of this reforms, have yielded outcomes that are still significantly marked by features of the past.

This includes what regards as a failed attempt to introduce social health insurance in the late 1990's of which private health insurance was seen as a key element. Viewed in an international context, in our view, this rants countered to the basic principles of social security that immerged especially after the World war two in which universal

access and solidarity are the corner stone. The wave of new liberalisation that started over four decades ago, in which privatization of health and retirement insurance were the whole marks. That's what [indistinct 0:52:50.1] mainly the countries of the global South has passed its peak, in the light of the fact that its outcomes have generally been the exact opposite of what social security set out to address and achieve.Hence lessons have been learned as underscored by the 2008 report of the world health organisation, which identified commercialisation as one of the key factors which prevents nations from reaching their health policy goals.

It states that commercialisation has consequences for both quality and access to care. The reasons are straight forward. The provider has knowledge has knowledge the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient. The point we are making here, is that some of the issues identified by the revised statement as distortions or failures, are actually typical objectively inherent and systemic and therefore not necessarily abnormal at all.

Our submission cited an example of the United States as described in the work of Robert Wood Johnson Foundation which estimates that the number of the insured in that country, could jump to as much as sixty five million in 10 years, as health costs

double. We are here to see the progressive, but still inadequate measures introduced in terms of the affordable care act passed in 2010, the so-called Obama Care. Hence as a poor mirror image of the US private health system, for us it is not surprising that healthcare in South Africa is expensive relative to the country's wealth, a fact which is also confirmed by the OECD Report in a paper that states that private hospitals in South Africa, are least affordable when compared to OECD countries even for individuals of higher levels of income. Thus regrettably, missing amongst the issues for consideration in terms of the revised statement is a relevant international comparative analysis with regard to the cost of private health insurance system in their different configurations.

While there may be an appreciation that access to health services and care is a constitutional social economic right, the approach taken by the HMI within the framework of the theories of [indistinct 55:38] appears to us to straightjacket this inquiry within a new [indistinct 55:46] paradigm. Hence even the discursive language in the revised statement, is heavy with often inaccessible and problematic new liberal jargon that even refers to sick people as markets, consumers, etcetera etcetera. Therefore, for some of us whose ideas and assertion fall outside this paradigm, that envisages remedial messages to correct market distortions and failures that are seen as abnormal, we are weary as to the value of our submission.

So we are now raising the key issues, some of them arise from our submission, as well as the revised statement. According to the HMI, the [indistinct 56:38] of this inquiry is by and large, narrowly focused on determining whether or not there are features of the private health sector that undermine competition. None the less, we note that the scope has been broadened beyond what the HMI states as a task of this exercise. It may be logical and we certainly support this, but we are concerned that the broadening of the scope leaves out some of the key and actually obvious considerations in this inquiry.

In our view, this is because the prevalent ideological paradigm of new liberalism that looms so large in the revised statement, the HMI states that the revised statement outlines its current thinking, even though it is also saying that it is still presently in the investigative phase. Therefore if you [indistinct 57:34] that the statement highlights issues that are currently considered as priority focus areas of the HMI going forward, then in this presentation, we seek to critique the approach taken on some of the issues to raise issues that appear to have been ignored or not considered as priority issues going forward, whilst at the same time we emphasize some of our original assertions.

We are dealing with the issue on risk pulling failures. The revised statement seems to appreciate that risk pulling failures are common to all private healthcare systems. In

other words, they are structurally objective and systemic where health is secondary to the primary motive of profit maximisation. Yet it appears as if the revised statement seeks to revert to its investigation back to a discussion on a mechanism such as the risk equalisation fund, or reinsurance arrangement pool.

We have a fundamental concern about this discussion about possible measures such as the risk equalisation fund, because there appears to be no appreciation of the context of this inquiry that is the transition to universal health coverage in the light of the White Paper on the national health insurance. This is the direction that the country is taking on the back of the failed attempts to introduce a social insurance model in the 1990's.

In our submission, we quoted the Minister of Health, Dr Aaron Motsoaledi saying that the artificially high private healthcare costs need to come down as one of the 2 major conditions necessary for the successful implementation of the NHI. This is the context of this inquiry and therefore, reverting to social health insurance model would be of little value in terms of the long term trajectory of the reforms that are underway.

We would have no concern if there was also a discussion on how to address the high costs of private health sector in the context of environment of a single payer. In this regard, some valuable international experiences could also be drawn from. Therefore for us, it is extremely problematic that the revised statement appears to be indifferent or

oblivious to the looming context of a move towards universal health coverage. Yet it begins to revert back to a discussion on social health insurance as it broadens its scope of inquiry.

Therefore whilst we think that a discussion on the failure of Government to implement social insurance arrangements may be part of some explanation, but actually it is an irrelevant discussion in terms of where the country is trying to move towards. On market power and concentration, we welcome the fact that the issue of market concentration in the private health system across the spectrum of medical schemes, administrators, hospital groups, pathology firms and others has been identified as one of the key issues of investigation according to the revised statement, indeed there is an appreciation as market consolidation increases the risk of anti-competitive conduct through the exercise of market power increases.

In our submission, we have alluded to a number of studies that confirm this, including by Mc Intyre and Gilson Development Bank of Southern Africa and [Econex]. The study by [Econex] identified 4 key factors as primary causes of increasing private costs. Firstly, the acquisition of beds, expensive technology, concentrated ownership and commercialisation. Some of these have been substantially conversed in the revised statement therefore there is no need to deal with them here. However, we are

concerned that the revised statement seemed to suggest that the HMI would merely consider the consequences of the concentration and thus disregarding the causes.

Therefore it would appear as if the question of the objective structure of this industry across the board would be entrenched while some remedial measures directed at subjective behavioural or market conduct would be the only area where some solutions would be forthcoming. This then to us, apparently rules out the question of the restructuring or breaking up concentration in terms of the investigation of the HMI. Therefore we would like to reassert that the prevalence of [indistinct 1:02] police across the value chain, is a fundamental problem that must be addressed, from which the issue of the market conduct especially with regard to the hospital groups factor, is a necessary by-product given the prevailing de facto deregulated landscape.

The Department of Health reports that the private hospital market in metropolitan areas which caters for more than half of the medical scheme population was concentrated by 1999. This was from the Minister's presentation to COSATU. Thus accordingly, between 1998 and 2000, a significant change in terms of concentration in ownership in the private hospital landscape took place. This sharply coincided with the escalation of private hospital cost in real terms and since in terms of the 2009 prices.

Similarly, this also sharply coincided with the escalation of returns on investment for the hospital groups. We have cited the report by Genesis Analytics which documents an analysis of the return on capital employed in the South African operations of Medi Clinic and Netcare, the 2 largest groups. It analysed the return on capital employed before and after 2001. Accordingly between 1998 and 2001, Medi Clinic's average return on investment was 14%. Between 2002 and 2011, return had increased to 23%. Return on capital for Netcare averaged 15% between 1997 and 2001. Between 2002 and 2011, that number had jumped to 22%. We welcome the fact that the revised statement identifies the issue of profit rates for investigation.

Thus from our point of view, we want to underscore the points that merely focus on behavioural market conduct was leaving the existing giant monopolies intact of which the market conduct is a by-product, we place the outcome of this exercise into question, even from a point of view of the Competition Commission.

We believe that the fact that the measures that have taken place have been approved by the Commission's Tribunal may account for this. Then we deal with the over-capitalization in terms of beds. Alongside the overuse of expensive technologies as noted in the revised statement, it is necessary for us to emphasize over-capitalization in

terms of beds. We draw this from the study by the Development Bank of Southern Africa which identified the increased acquisition of beds as one of the factors contributing to the escalation of cost which we think must be considered.

Accordingly, the private sector had a bed over-supply of ten thousand by 2008 as a result of adding four thousand beds between 2004 and 2008. It maybe unclear to us as to the situation in this regard presently, but this is a matter that must be taken into account in the inquiry. Then we deal with outsourcing and concentration in administration.

Related to this question of concentration, we would also like to underscore our concern with regard to administrators of schemes in a manner that has not been considered in terms the revised statement. This pertains to not only the question of concentration with regard to administration of medical schemes, but equally importantly, the correlation of outsourcing of administration in higher costs. In this regard, we base our analysis on the 2013/2014 report of the Council of Medical Schemes which was the basis on which we had to mount protest marches on 3rd October 2014 as NEHAWU.

Accordingly, we found that in 2013, the self-administered open schemes experienced an increase of 3% in the cost of administration and management healthcare services. From 128 in 2012 to 132 in 2013 in terms of per average beneficiary per month, while

those open schemes that have outsourced their administration experienced a 6.8% increase, thus effectively the outsourced or third party administered open schemes paid 12.3% more for administration in managed healthcare services than self-administered open schemes.

Similarly during 2013, where there were 8 self-administered restricted schemes representing an average of 281 489 beneficiaries and fifty nine third, party, administered restricted schemes, represent an average of 3.6 million beneficiaries. Those with outsourced or third party administered restricted schemes, spend on average 37% more on administration and managed healthcare fees than their self-administered counterparts.

The problem we want to underscore in this regard is that it is obvious that outsourcing of administration is a clear influence in the escalation of non-healthcare costs. Therefore this is a matter that requires an investigation by the HMI as it is also related to the dynamics of the market structure of administration schemes. This is apart from the fact that from our point of view, outsourcing deepens inequalities in our society, given the fact that it is often the terms and conditions of workers that become the basis of the competitiveness of companies involved and thereby their domination in the area.

The issue of external factors, the HMI identifies the question of the nurses' salaries amongst what are called external factors that are apparently beyond the control of the market factors, contributing to the adverse market outcomes. In this regard, public sector salary increases are blamed for the rising cost in the private sector, despite the fact that there has been a considerable rise in profits accumulated by hospital groups as alluded to in the foregoing in terms of the report of Genesis Analytics and cited in our submission.

It goes without saying that this reflects the views of the private health employers. From our point of view, underlying this is the fragmented 2 tiered health system in South Africa. The fact of the matter is that pay in the private sector is better than in the public sector, thus rather than this being an external factor beyond their control, the private sector itself, deliberately ensures that this is the case so that there could be drainage of medical workers from the public to the private sector. Hence we concur with the White Paper on NHI when it says that on the contrary, high costs in the private health sector also contribute to the high costs of labour in the public sector, as the public sector attempt to match the high salaries in the private sector.

Therefore we would argue that the investigation by HMI must rather focus on the relationship between pay of the nurses and what appears, to be the run-away profit rates in the private sector. On regulation, we note HMI recognises the need for regulatory intervention but with a view that would create normally function in private health market. On our part, we support such interventions that are necessary in the absence of a single pair to the extent that they would help reduce the high cost in private healthcare.

Hence we argue that in the interim, the Department of Health must re-introduce the national health reference price list. We believe that the Court ruling abandoning the published 2010 reference price list, did not in any way, prevent the Department from following the correct procedure and re-establishing the referenced pricelist.

The other regulatory matter that we wish to draw to the attention of the HMI, relates to what we consider to be self-enrichment that is taking place in the boards of trustees of medical aid schemes, particularly in the Government employees medical scheme. For example in 2012, according to the report of the Council of Medical Schemes, the average annual stipend of each of the trustee of the top 10 medical aids, was R270 000 which translates to approximately R23 000 per month, whilst the 2013/2014 annual report of the Council of Medical Schemes shows that GEMS has spent an average

stipend of R568 000 per trustee, totalling R7.9 million.

This is taking place at a time when GEMS like other medical aid schemes that have outsourced their administration, have seen the costs rising at double the rate when compared to schemes in which administration has been kept in-house or insourced. This is part of the rise in non-healthcare costs, taken away from every Rand of a members contribution and so we propose that this matter must be looked into by the HMI and appropriate remedies be recommended.

In our conclusion, we have expressed our concern with regard to the overall thrust of the inquiry which appears to disregard the context of the move to universal health coverage and single pair. A move that is in keeping with the principle of social security, including our constitution in terms of Section 27.

We do appreciate that this inquiry is taking place under the auspices of the Competition Commission and therefore necessarily it is focused on determining whether or not there are features of the private healthcare sector that undermine the competition. We are convinced that some of the distortions or failures identified are inherent and systemic in the contemporary capitalist markets, especially regarding the question of market power and price.

Retirement insurance is another form of privatized social insecurity that reflects remarkably similar characteristics not only in South Africa but in other parts of the world where there is a prevalence of private arrangements. Nonetheless, we do recognize that the HMI has identified some of the pertinent issues afflicting the private health sector in terms of high costs which we hope its outcomes will go a long way towards finding solutions.

These include exorbitant costs associated with fee for service model, imbalance in tariff negotiations between purchaser and providers, information asymmetry between patients and providers, small and fragmented risk pools in each medical schemes and others. In the time available, we have attempted to respond to some of the aspects of the revised statement and made proposals on other issues that may be considered for investigation even within the prevalent paradigm of the inquiry.

We believe that these issues are also influential in determining the current exorbitant costs of the private healthcare and can be addressed by the inquiry, thank you very much.

JUSTICE NGCOBO Thank you, do you have any questions?

MR SELEKA On the aspect of regulation, the last point before your

conclusion, particularly in regard to payment to trustees, you are requesting the inquiry to look into this aspect and recommend appropriate remedies. Do you have any suggestions to make to the panel as to how this issue could be resolved or regulated?

MR MORALO Our suggestion is that the issue of the trustees must be regulated in a manner that it is going to minimize, because you can see that in the various schemes, the tariff is different, meaning that it depends on what the board of trustees decide how much can they pay. Then we want a situation where it can be minimized in terms of regulation published that each medical aid should pay the minimum of these costs and that any board of each medical scheme should not be allowed to determine their own tariff. It should be regulated in a manner that all of the people comply to that standard.

MR KGARA Perhaps I should add because schemes would have annual general meetings and they do elect trustees. I think at least we expect from the inquiry, is some recommendations that give some pointers with regard to acceptable issue like stipends which have now amounted to actual income generating schemes for those who are on the boards, so in the protest action that we have taken in 2014, because most of our members are in the public sector as NEHAWU, we have raised with GEMS and they undertook to look into that, so it is also another approach where

members of medical schemes themselves begin to challenge the practice, but it would be helpful which is what we are trying to say, if the inquiry gives some guidance or direction in this regard, thank you.

MR SELEKA Still in regard to costs, you cite the report of [Econex] in regard to factors identified as the drivers of costs in the private sector. One of those factors is expensive technology. This morning we had a presentation by a society that represents cardiologists and they advocated the use of new technology because it is necessary for the practice. What is your stance in regard to the use of technology, because I see you make mention of the [Econex] Report. There is no indication from your presentation whether you agree that technology is necessary, the use of new technology or not and if so, whether you have your own independent reasons for either being critical or in favour of?

MR MORALO I think perhaps one must start by saying that in principle, we not opposed to progress, including the use of advanced technology in dealing with ill health, but as it happens in our private health industry, an issue which is also raised in the revised statement, there is also a problem where there is almost market inducement in order to ensure that people are given not so many options but they use expensive devices in order also to get returns from investments from those

technologies.

So, there would be technologies that are highly expensive, but valuable, but there will also be technologies that are highly expensive but where there are alternatives, to them. I was fortunate to have been able to observe the Cuban health system which whilst it has advanced technology, but most of their approach is very much different from what may be found in South African hospitals, and yet they've got impressive health outcomes.

MR KGARA Okay, thanks, as my colleague has indicated that we are in support of technology to assist, but one of the things that we have noted is that in [indistinct 1:23] is that we don't want a situation where also in those advanced technologies, there are hidden costs, we need to have a clear situation, that there is no kind of a situation where for example, as indicated, the company that will introduce, for example, a pacemaker, will then sell a pacemaker at a higher and an advanced pacemaker for an advanced price, but whenever that pace maker is being distributed, it will be accompanied by individuals, wherever it goes.

The question is that and we are not being told, in terms of what caused that price and the certain process that goes with that thing. To me, we view it as hidden prices, that makes a new technology more expensive and then we want a situation where as we

advocate for a better technology to improve the life of our people, we should not have a situation where there are hidden costs where no one understands what informed those costs on those prices, on those products that we just referred to, thank you.

MR SELEKA Thank you.

ADV PILLAY (SC) No questions Chair.

DRS VAN GENT You will have to excuse me, I am from a different country and I know your remarks and submissions, which I read with a lot of interest, very interesting. I am sure I missed some of the finesse of the remarks, but I want to take you back to 318 and there you say that on our part we support such interventions that are necessary to in the absence of a single pair, to the extent, they would help reduce the high cost of private health care. It is a general statement, isn't it? It's a statement about in the absence of we have not reached the stage of the NHI, in the meantime we could embark, or the government could set on a number of measures that would reduce cost for the people that are on medical schemes.

And you give an example of the reference price list as a possibility. I take this statement as a general statement, so in the meantime, when we not reached a state with the NHI, you would also endorse measures that bring back costs. Now, in that light, I

do not fully understand your opposition to risk adjustment, because risk adjustment is just about doing that. You refer to the incomplete social health care system, of course, which broke off, if I am right, in 2007, where you didn't complete the total introduction implementation of social health care system.

One of the elements that were not tried, are implemented were risk adjustment. If, for example, we turn out, in our research, and as you rightly state in our revised statement of issues, we announce that we would research the effects of risk adjustment. If it turns out to be the case that risk adjustment effectively would reduce cost for numbers of medical schemes, would then your remark in 318, apply again, that you would endorse such a measure?

MR KGARA The problem is, okay, maybe I should start by saying that we, in the 1990's opposed such measures, as a risk equalization fund, and so it is a principle opposition, that whilst we say that in the interim measures that are necessary to reduce costs, must be taken, we will not support measures of a nature that they actually introduce a new system, a form of social health insurance, which in any event, maintains the two-tiered health system in the country. So, in itself, one would imagine that it would be a medium to long process of doing that at a time when you should be spending more on shifting to a new system.

So, we will oppose that, because it will be an opportunity missed. Actually, what we are dealing with, underscores the need to move rapidly towards, a single pair, so I think we are careful in saying, that we support interim measures that are directly reducing costs and not so much about dealing with risk management, as it were, thanks.

DRS VAN GENT Even if they reduce cost, you will not support them?

MR KGARA As I say, it is a principle opposition to that model, because we will be going back, actually.

DRS VAN GENT Forgive me to try and understand precisely what you say, so South Africa has introduced 3 out of possible interventions in the insurance market that would contribute to a social health care system, a social insurance system. The element still missing that you would find in a number of other countries in the world is risk adjustment. How would the introduction of risk adjustment, in itself, prevent you from going into the next stage of implementing and introducing NHI in South Africa?

MR KGARA In a sense, I think, it is a matter of detail, but I would say, the issue for us, is that it leaves the overwhelming majority outside health insurance and it is not given that you may then proceed to a single pair, once you begin to do that. So, as I am saying is, it will be an issue of detail, but, from where we stand,

there has been way too much time that has past, where we could have been far by now in terms of universal health insurance. So, I guess this is a structural change when you introduce such measures that begin to defines, even the direction of where you may end up. So, we will oppose it from that point of view.

DRS VAN GENT I am referring to paragraph 313 and 314, where you refer to the number of closed schemes, that are still self-administered and some are, or the majority is administrate by professional organisations and the cost involved by changing from a self-administered closed organisation to having your administration done by one of the administrators. You only refer to the costs of the non-healthcare related costs. We have seen quite a bit of these closed schemes, who chose to be administered by the large professional organisations and bearing the costs involved in that? As an economist I would say, there must be a benefit to having your administration done by these professional organisations, although the costs are higher, there must be a benefit to it, a benefit, I presume to the members in terms of quality of the service provided, and better coverage. How do you look at that?

MR KGARA It may be true that there more larger firms that specialise in administration and would provide benefits which probably would make sense to the schemes, but the point we are making, is that, it happens often at the expense of the

conditions of workers, as a competitive element and from the point of view of the schemes, as it happens, we see now in the universities is a huge issue, if you are a scheme, you want to externalise all other costs of labour. Transfer them to some third party, which then means deterioration of condition of services. So that is how we look at it. It deepens the inequalities in our society. It becomes surprising when people see, when we talk about lack of social cohesions, but these are the kind of things that create, what we are seeing in society.

So, even though they appear distant, we think that the Commission to the extent that such mechanism is the outsourcing of administration have an impact on the non-health care cost, must be attended. We also raised the issue of what is called stipend, we do recognise that there is responsibility of the schemes themselves, but I think that it is an issue that also has to raised sharply to be redressed, thank you..

DRS VAN GENT As you might have seen, in our revised statement of isssues, we will look into that, of course. Thank you very much for your answers.

JUSTICE NGCOBO One of the purpose of this, general submissions, this general sets of hearings, was to provide ordinary people with the opportunity to come and talk to us about their experience of access to healthcare services and one of the points that COSATU made to us, in its submission was to emphasize the need to allow

ordinary people to come here and make oral submissions as to their experience. Have you had an occasion to speak to your members, or get some of them to come and talk to us about what their practical experience has been in regard to access to healthcare services?

MR KGARA I shall start and my comrades will add. Perhaps, because we are a health union, but also as part of a wider COSATU, we take seriously, the issue of health and social security. So for a considerable time up to now, we have been engaged in processes of education of members, with regards to our advocates of the national health insurance. Not so much with regard to the submission here, but in the process, when we discussed the health system, also in our mobilisation for the 2014 protest on GEMS, we listened to what they had to say about their experiences, so it is and we notice that you intend to undertake hearings in the provinces as well. It is an issue that we could participate at that level of ordinary members of our unions, giving testimony to their experiences as scheme members.

JUSTICE NGCOBO Yes I understand but, are you aware that there was a time that was allowed for people who want to register to provide oral submissions to come to us, because the whole purpose of the exercise was to get to an understanding of how many people will be there in Kwa-Zulu Natal, in the Eastern Cape and in the other

provinces, so that we can make then necessary arrangements to go and hear those people.

All I want to know and this is the point that you emphasised when you made the submission to us, that ordinary people must be allowed, so all I want to know is, whether or not – have you been able to put together a list of the individuals who are going to come and talk to us about their real life experience in accessing healthcare services at private institutions?

MR KGARA I should say, if the question is that whether we have organised members to come and speak as yet, we have not, but it is something we can consider, in fact, I personally have seen, noticed that there have been individuals coming to testify, to give testimony and I thought, it is a very useful exercise, because then, unlike myself, these are people who will be speaking on their real experiences. So, it is probably a useful way of making the issues come through to the…

JUSTICE NGCOBO I am simply ask this question because, this was a recurring theme in the submissions that you made to us, emphasising the need to allow ordinary people to come here and that is why I am asking you that. Now, one of the issues that you raised, is the need for this inquiry to align these processes to the NHI, is that right? So what do you mean by that?

MR KGARA Well, I mean, we began by raising the remarks of the Minister in talking about the high private healthcare costs as one of the 2 conditions for a successful creation of universal health coverage. So, our understanding in the discussions we've heard, within their lines, within Government as well, is that the high private health costs are a major impediment for the NHI. But, part of why we sought to raise this in the way we do, is that we are surprised that there is no exploration of in tackling the high costs, whether there could be a different configuration in the paying system, other than the current reality, in terms of the focus of the Commission.

So we raise it to say that, we think that in broadening your scope, you should include considering how differently things could be done including where there is an environment of a single pair. We know that in other parts of the world, where there would be elements of the private sector, the role of a single pair plays a big part in influencing the levels of health costs in the private sector, but this doesn't appear to be of consideration here. So that's the point we are raising.

JUSTICE NGCOBO But is there anything though, that prevents you from raising those issues?

MR KGARA Well I suppose we are when we are here.

JUSTICE NGCOBO Here? I understand. My understanding of the terms of reference and the subsequent initial statement of issues, it was broad enough to allow for all views to be expressed, with a view to finding the solution. Do you feel that you have not been given the opportunity to raise the other issues that you had wanted to raise?

MR KGARA No, Chairperson, I think perhaps let me indicate that we are not complaining, we are only being critical of what we see as a thrust of the inquiry and we think the problem with issues such as these, is that you create a framework in what to investigate, which has almost a particular outcome, eventually. Even though you may be accepting different views, so, in reading the revised statement, it is clear to us, that there is a particular framework which frames out of perspectives.

We come here to support interventions that, to the extent that they can reduce the currently high private sector costs, will be of use, even in the context of a move towards a, universal health coverage. So, we don't think that we are prevented to raise, but we are being critical of the thrust and we did indicate already that some of the historical decisions of the Commission in our view, had influenced the current predicament of extremely high – so, there is a perspective we have about – and we understand the focus of the Commission as such, but we don't think that we are being

prevented, we are only saying that we are framed out in our views in the paradigm.

JUSTICE NGCOBO You do understand that the health market inquiry is being conducted under the auspices of the provisions of the Competition Act, in particular those provisions that deal with competition issues and I think what would be helpful for us, is to articulate within that context, what can be done, if anything. If there isn't anything that can be done, what then is the solution? So that we can accommodate and consider your views in that particular context and make sure that your voice is heard in that particular context. Do you understand that?

MR KGARA Yes, we appreciate that.

JUSTICE NGCOBO That is why I will be concerned that if there is a suggestion that there are issues that you wanted to raise, but which you felt that you couldn't raise, because of the way the inquiry is structured.

MR KGARA Yes, I am running a risk of saying what I have already said.

JUSTICE NGCOBO I understand that.

MR KGARA I think that perhaps we are dealing with an institution as such, not so much the panel or – and we understand your mandate, even our submission indicates that we appreciate that this is your task and we welcome the fact that you broadened your approach, but in broadening, you are moving in a particular direction of which we are critical. That's the point we are making, but this we understand is part of engagement, isn't it that when you are done with your investigation and making a report, you will release a report, which is also going to be discussed, so it is a – we see it as – because we had already made a submission, which we were earlier talking about and some of the issues we are reasserting, have been raised in that submission, but they have not featured as issues of consideration. So, necessitating that, perhaps we must raise this issue, take this opportunity to do so now, while you are still investigating.

JUSTICE NGCOBO Any more questions?

PROF FONN Thank you for your submission and I appreciate your points about the paradigm difference. I wanted to ask for clarity on – I suppose it is similar to the questions you had before. You correctly, I think, identify the problem with the fragmented risk pool, at the end of your document and I suppose crudely, one could say that the NHI is a single risk pool, where all of us, are in that same risk pool,

so I have difficulty in understanding the objection to a phased risk pool. So the notion of risk equalisation is increasing the risk pool and in fact addressing the issue that you raise about the fragmented risk pools.

The risk equalisation is a method of enlarging that risk pool, which then, seems to me, to not necessarily be at odds with the notion of all of us in South Africa being in a single risk pool, which is what the NHI would ultimately in fact be doing, if one accepted this terminology. So what is my question? My question is, I suppose, I mean, I get your point about in principle objection to 2 system, but we do have this reality of these 2 systems and is it for you an absolute line, that incremental increasing of the risk pool, is problematic.

MR KGARA Yes, but it also is – we have – I should say that, in 2009, the Government of the day got a mandate to introduce the national health insurance, in 2014, it got yet another mandate to do the same and in the course of this second mandate it outlined what it called the 10 year plan to do so. Beginning with the pilot sites, so the whole context is a transition, so beginning to introduce now, almost parallel processes, would have implications.

The second point I should raise is that before the inquiry – maybe I shouldn't be raising this, but I should, I must. Before the inquiry, when this issue was muted with us, we

supported it, but we never thought it would an issue of competition, but more of on an inquiry as to what regulatory measures can be introduced and at that stage, we were also entertaining, not only the private health, but also pharmaceutical industry, because some of the costs come from there, so, once it's here, it's here. So, it's about competition, so we are raising this because we have raised that before, but that is what the authorities have done and we do think that the fact that you are opening the scope as well is a good thing. Hopefully our views can also be entertained in that context.

JUSTICE NGCOBO Very well, thank you for making time to come and make the presentation. Thank you so much for that.

MR KGARA Thank you.

JUSTICE NGCOBO That concludes this session. Do you have a question?

MR SELEKA No I agree, that concludes the session.

JUSTICE NGCOBO Now as I understand it, next week we are not going to be here. Is that right?

MS MUVANGUA Yes, that is correct Chair.

JUSTICE NGCOBO Okay, we are going to be at the offices, of the Health

Market Inquiry.

MS MUVANGUA Yes, that is correct.

JUSTICE NGCOBO Okay very well, so we will start at Tuesday at 09:30 at the offices of the Health Market Inquiry. Thank you.

[END OF RECORDING]