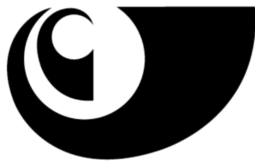

Market Inquiry into the Private Healthcare Sector

Public Hearing 5
Day 1

held at

HMI Offices, Trevenna Campus
Sunnyside

on

3rd May 2016

Panel:
- *Chairperson: Justice Sandile Ngcobo*
- *Professor Sharon Fonn*
- *Dr Lungiswa Nkonki*
- *Dr Ntuthuko Bhengu*
- *Drs Cees van Gent*

Stakeholders/ Presenters:

- *Dr Izak Fourie* *pg. 03 – 105*
- *Stephen Laufer* *pg. 105 - 130*
- *Prof Andrew Sarkin* *pg. 131 – 249*

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Competition Commission of South Africa
3rd May 2016

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Competition Commission of South Africa

... *Date: 4th May 2016*
Editor: Mr Godfrey Malgas

[START OF FIRST SESSION]

JUSTICE SANDILE NGCOBO Good Morning and welcome to the Health Market Inquiry Public Hearings, continuation of set 1 hearings.

JUSTICE SANDILE NGCOBO For the record, please start by stating your full names?

DR FOURIE Izak Johannes van Heerden Fourie.

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JUSTICE SANDILE NGCOBO Now I understand that you have prepared an oral presentation that you want to present to us? Are you ready to make the presentation?

DR FOURIE Yes. Thank you and thank you for the opportunity, I will get back to how I got here. The Agenda is a little bit of an introduction why me, a bit of the context, the self-evident truths which I think guides us all who are concerned about

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the South African health sector. I think an important theme from my side, is the meantime. There seems to be that the country is obsessed with an NHI and the development towards an NHI and we tend to forget the meantime. A few facts about the South African private health sector, the radical cost reductions, which I think are

now what we should aim for, not the marginal. The question of the role of the private sector within the context, because I think that determines on what we see and then perhaps a few low-hanging fruit that can be easily achieved.

First a bit about myself, I was invited, I don't have a constituency here, I'm here in my personal capacity, I have a wide experience of the South African health sector. I was a private practicing urologist I managed 2 of Medi Clinic's hospitals, for a whole number of years I was in charge of the South African Mining Industry's healthcare system which at the time, had more beds than any of the 3 big hospital groups.

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They were run very differently and I still believe one of the examples of how we can provide far more cost effective, specially hospitalization, the last number of years, I have spent advising medical schemes, mostly restricted member medical schemes, so I'm not as an expert on the Discovery's of the world and I have a long, given having worked for the mining industry for so long, I understand occupational health, Workmen's Comp and the rest.

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Academically, I am a, urologist by training. I, with Professor George Marx from Pretoria, started actuarial training and spent more than10 years as an associate

professor in actuarial sciences. I did some health economics training and the last few years have been quite involved with the healthcare side of the Harvard Business School and a little bit of what I am going to say, would come from there. Conflict of interest, I have an indirect minority shareholding in Insight Actuaries and Consultants, who I believe you have interacted with, [Christoff and Barry Childs] and also in Nurture Health which is a sub-acute hospital group mostly rehabilitation.

10 I am mostly as a consumer and an extremely concerned citizen with grandchildren, worrying about what the healthcare system is going to look in some time. I have gone through I think a lot of what has been before you, read the re-statement of issues etcetera and I will try not to repeat those, because I don't think I can add very much to that.

Now the context, the first self-evident truth and we tend to run away from this, is in spite of spending more money than upper middle income countries, we have 20 significantly poorer results and this preceded the HIV/Aids epidemic from the first national health accounts Di McKintyre and some of us did in the early 1990's, so we are not spending our money efficiently clearly.

Secondly, that a large part of these poor results is based on the current two-tiered healthcare system, which we inherited, developed and you know the figures of the rest. I think the point I want to make is, that this is not sustainable from many aspects and lastly, the words in the black, this is fundamental structural changes where we need, not band-aids and Disprins, but surgery, which normally has a bit of blood and post-operative pain. I do not believe that with tinkering at margins, we are going to achieve much.

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The third truth is that the Government's answer to the preceding comments is the introduction of a universal compulsory national health insurance system for all people in South Africa. I am not going to get into the merits, demerits and affordability that is a debate that is going to consume South Africa for the next fifteen years.

20 I think what is very important is this fact, that the implementation will take place in 3 phases over a fourteen year period and the first phase which is predicted to be 5 years, will focus on strengthening the service delivery and improvement of the quality in the public health sector. Now for any of us who work close enough, know 5 years is not going to solve this and so to my mind, when we talk about an NHI as

an eventual goal, it is not fourteen years, we are behind the schedule in any case and I think a lot of the debate, or a lot of the issues that I'm saying, is we can't wait for NHI, we also don't really know what it is going to look like. What we develop, are probably going to contribute to what we see. A few facts about the SA private health sector, I read Alex's review he did for you, Alex van der Heever and the Genesis Report, there is nothing really that anybody can add. The facts speak for themselves. What is quite clear is that our problem and I can tell you this from managing medical
10 schemes is private hospitals, specialists and oncology.

Now a number of years ago, managed healthcare mostly on the American model, was held out as some panacea that will manage the cost and the quality. I think like in the United Sates, it has proven to be a very blunt instrument. I'm not saying it had no effect, but certainly not and I'm sure you've seen the figures that the real rise in private hospital expenditure mostly coincided with the introduction of hospital
20 utilization plans by the managed care organization, so I think it has a place, but it is not going to save the day by a long measure.

The other element that is frequently held out, which I'm sure you've come across in different models, is the alternative reimbursement models that are out there. Now in theory, reimbursement models should introduce efficiencies. However, the way that it has happened in the South African private healthcare sector is in my view, largely an entrenchment of the inefficiencies of the past and if it's well managed, the only guys who are going to make money out of those, are the private hospitals themselves by benchmarking on historic data and then managing the fact which we all agree is in
10 the system, out for this.

I do not believe that alternative reimbursement models in the current environment, is going to contribute significantly to the efficiency of the system. I'm not saying that it's not theoretically possible, but all the ones I have seen and I have been exposed to I think most of them, if not all. Then the tariff debate which I'm sure you've heard both sides whether it's central or not central, my own view is that it is probably better
20 central. I know it is a Competition Commission investigation, but it is probably more how you do it, than whether it is central or decentralized.

Then in the previous documentation, there is quite a bit on information imbalances and asymmetry which I will make a comment, I think it's a major problem. It's a

major, major problem. The protection of data as you've experienced especially early on and the people holding onto their data at all costs behind walls, is a major problem, so it is not just at patient level, it is also at other levels, so I think that's a major problem.

So perhaps just my view to add to what you've already heard in facts and figures from people who spend a lot of time putting together systematic reviews. This is my
10 view of what's happening around us and with all due respect, I think a lot of what we are busy with here, we are just moving the deck chairs on the Titanic, we are not removing the iceberg, we're not seeing the iceberg and I don't think we are near close enough or near enough in the right paradigm to, I came across this, it wasn't written about South Africa, it was written about Canada, but I think this is equally true for the South African private health sector.

20 As I say, I work mostly with restricted membership schemes where you also have a close association with the employer and quite often, the trade unions and all of this. The South African private market via the medical schemes, are fast pricing itself out of its traditional customers and I see no trend where that will be reversed. You've all looked at the relative financial health of the lower cost options currently in the

market. They are also not sustainable, especially if you factor in the evolving HIV/Aids epidemic that we simply have to factor in, it is not going to go away.

So, what do we need? If the private health sector has to play a part in my grandchildren's healthcare system, we need a radical reduction in the cost of providing healthcare and via my association with the Harvard Business School, I've had quite a bit of contact with these 3 organisations in India and perhaps for those who are not familiar with them, a few words. [Aravant] was started by an ophthalmologist who developed rheumatoid arthritis and couldn't operate anymore and he had the concept of eliminating needless blindness.

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I will say a few words about South Africa just to try and make the point. This has grown into an organisation, it gets no State subsidy, it is private, there is a wonderful book Infinite Wisdom, how [Aravant] became the world's greatest business case for compassion, so this is not a charitable organisation. It is a business case for compassion. They are now doing around two hundred thousand eye operations a year in India, which to put it in perspective is a third of the NHS in the UK at around 5% of the cost and better reported results, so first of all, it has been done in a large number.

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Now I know cataract surgery is simple and easy, but they have done it, they are providing and this is where I come back to the information asymmetry, they publish all their results, they use the latest technology, they use specifically trained semi-skilled, un-skilled, matric girls go out into rural communities in India and do a first line, take these new fancy pictures which gets transmitted, interpreted. I think the bottom line is they are doing this on a very large scale and they are doing it at a fraction of the cost in a community which income wise, is probably as poor, or poorer than the South African community.

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[Narayana] does open heart surgery at about a tenth of the cost of what it costs here. They have just opened their first hospital in the Cayman Islands, a twenty minute flight from Miami and they are going to start off by doing it at about 25% of the American rate. Again, publish their rates, it compares well and then the last one, which is equally, is Healthcare Global which is a community oncology system, that provides oncology services again on a similar hub spoke using lesser trained people on the periphery technology to service the rural parts of India.

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Now I know there was a bit of controversy in the beginning about international comparison and whose, the most expensive and whose, not the most expensive, I

don't think that's important. I don't think whether we more expensive or less expensive than OECD is not there, we are too expensive for South Africa and I think the international comparisons, I would like to see, is to go and sit and seeing we're in Pretoria, is to say let me analyse [inaudible – audio off] and the Pretoria Eye Hospital. We know they are paying lower salaries, we know that, but it doesn't come close to [inaudible – audio off] the differences between [inaudible – audio off] I would like to compare Narayana [inaudible – audio off] and Healthcare Global to any South African oncology unit.

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I think a large part of this also and I'm coming back to what I think the role of the private sector should be, is for those who haven't read it, Prahalat's The Fortune at the Bottom of the Pyramid, where he says that with modern technology, this is not about healthcare, this is saying that you can serve the world's poor profitability, but then you need to look at that.

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Perhaps a few words about eliminating needless blindness, when I came back from Harvard last time, I was very inspired to look at a project in South Africa, we are busy with it, just the crude facts, South Africa has about between two hundred and fifty and three hundred thousand cataracts that are un-operated, people that are

needlessly blind, a simple operation that can make them see again. Their mortality rate is 4 times that of a sighted person and we are not operating, so what we are busy looking at, is as you may know, a lot of the South African eye hospitals are actually owned by the eye specialists and we started working to see whether we are at the margin of those facilities with this, can make a dent in this needless blindness around us, very much around the theme that we need to, the private sector needs a bigger base. It needs to provide a bigger service, look after more people.

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So the million dollar question, is can the South African private health sector, serve the uninsured population profitably and affordably? Not, are we going to bring medical inflation from CPI +3 to CPI +1, that is important, but that's not the real question. This is the real question, is whether we can get to serving the uninsured profitably and affordably. The low hanging fruit in the meantime and all of this I think is somewhere in the documentation you already have, perhaps I am just highlighting. Eliminating anti-competitive behavior, of course, that is important, but

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I remember one of the guys who tried to teach me health economics, saying that always remember that Adam Smith's invisible hand is all thumbs in healthcare and the Americans have proven that competition alone is not really an answer to healthcare.

Healthcare is a different commodity. I'm not saying competition doesn't play a role, but it's certainly not the only and there is an enormous amount of American literature around this, probably the most disillusioned private sector in Michael Porter on why competition has not worked. Regulatory review, the National Health Act, I told you I had an involvement in sub-acute hospitals, the hospital license application in, South Africa is unbelievably inefficient, it's really an impossibility. If there is to be a policy not to grant, just then state it, but if there isn't a moratorium, the process is a

10 nightmare.

We were involved with seventeen of which two were granted. The other fifteen are hanging the shortest one is for 3 years. Now just for a moment in the private sector, I have to hold the land for that period, because the license is given for a specific site. Now get a right to the site, apply and then for 3 years, it's that, so if we are going to play a bigger role, we'll have to streamline this, or develop a policy that we are not

20 going to allow further private hospitals.

The second one has been mentioned to you before, the Health Professions Council of South Africa, I think their ethical rules are sort of mid 1900's, they've taken no account of modern trends in healthcare and how teams work and how systems work,

so the Health Professions Council especially they have a policy document on undesirable practices which eliminates the employment of doctors.

One of the reasons why the mine medical service historically when the mining industry was at its height, worked so well, is because we could employ the doctors, because we could, the separation between the doctor and the private hospital is often used as an excuse for the obvious inefficiencies which exist, so the Health

10 Professions Council I think we need to look at. The Nursing Council and the scope of practice of nursing nurses, again in the mining industry, we had 3 nursing colleges where we trained them. We also developed a course which the Council registered on nurse clinicians, which did a lot of the service and similarly, they are on the Pharmacy Council.

I think in the documentation I read already a lot of these. Again, I think the paradigm

20 must be what must, we do, to radically reduce costs. You can have the highest ethical or professional standards, but if there is, a quarter of a million people out there needlessly blind, something is, wrong. We have a regulatory framework which in my view is wrong if that is the case.

The Medical Schemes Act and on this this you've probably had more than I can say to, mandatory membership from a risk pooling is obvious, however, I can tell you that the people can't afford it. So put in mandatory membership, you will have 2 effects. First of all, mandatory membership with a risk equalisation fund will have the poor subsidise the rich. I can give you a reference on the research report on this, but it's obvious.

10 So although theoretically, getting the risk pool closed is a good principle from many aspects, it is simply unaffordable. I mean we have many employers where the membership of the medical scheme is open, there are generous subsidy arrangements it is just too expensive. The guy can't pay it, he is taking money away from food or schooling or something else. The PMB's you've probably heard enough, I was part of the compilation of the PMB's in 2000. They are also not properly designed for South Africa and its realities.

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The concept I understand and support, but I think they need a very fundamental review, which if I'm correct is overdue by several years in any case. Low cost benefit options is obviously necessary, I am convinced that it should be within the

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Medical Schemes Act. I think that we must start looking at alternative funding mechanisms for the unemployed or certainly for the employed, but uninsured.
The solvency issues you've probably got more than I can tell you around it, I think we're slowly but surely moving towards a more rational solvency dispensation other than a blind 25%. The information asymmetry I'm a very big believer in the publications of results and outcomes. I see no reason why that shouldn't happen. Exactly how and what and make sure and the standards of that, but I think nothing

10 will improve the quality and reduce the cost as much as that if you force that.

We've been involved in looking at the private hospital groups at specific, I told you I was a urologist, so we looked at prostatectomies in one of the groups and it just doesn't make sense. The variation, everything else around it, so I think publication of results and outcomes is important. Public private partnerships currently, are extremely difficult to effect, but certainly there is a big potential for those. I don't

20 mean the current ones like at Groote Schuur and Bloemfontein, where you try and put a private hospital into an academic facility, that is not a public private partnership, that's expanding the beds, because what you find there and I've seen this happen at both the institutions, the profitable surgical type cases go to the private hospital, the

long stay unprofitable goes to the public part of it, so not the current, but certainly around that.

Then alternative funding mechanisms for the employed, but uninsured, whether it's insurance, term loans, we've got a well-developed term loan industry in South Africa. If you start using some of the more common confinements, my favourite cataracts and you create other funding mechanisms for selected, now I realise there are
10 significant risks to that, but it is happening and I'll rather let it happen in a regulated environment than in an unregulated environment.

Then the right international comparisons, we've got our eye on the wrong ball as far as the international comparisons in my book, is concerned. So and then perhaps just a word of comfort when you have to write your report, is there is nothing more difficult to manage, more dubious to accomplish, nor more doubtful of success than
20 to initiate a new order of things. The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all profit from the new order from the middle, ages in Italy [inaudible] thank you very much, your Honor.

JUSTICE SANDILE NGCOBO We will start with Dr Bhengu.

DR BHENGU Morning DR FOURIE, how are you?

DR FOURIE Good Ntuthoko thanks.

DR BHENGU Ja regarding the, I will just start with the mining hospitals. You say there are lessons to be learnt by private sector. Is the doctor employment model the single most important lesson for industry there, or are there others that you want to highlight?

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DR FOURIE Perhaps just to clarify for the people who are not familiar with the mining industry, in 1990 when my association with the mining industry really started, the mining industry employed eight hundred thousand people. It now employs about three hundred and ten, three hundred and twenty, so we've seen a massive shrinkage and so the hospitals are no longer the hospitals they were built for a hundred and twenty thousand people.

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I think there are 2 things. First of all, employment of doctors, in my view, the best use of nurse clinicians, I mean even the senior people didn't see a doctor first and again, it was very protocol driven, very, I mean we had standard guidelines for all the common conditions and these were followed, nurses in general follow protocols better than doctors, so I think it was a whole lot of things.

There were advantages. First of all, the hospitals had been written off, because of the South African tax systems for mines, because they are on mine property, so there were certain advantages to it, but they were run as cost centres. They were run on a budget and they made use, as I said, we had 3 nursing colleges affiliated to universities. We trained the people we developed and later gave it to the Department of Health, the nurse clinician training course.

If you ask me, the single biggest one was the more appropriate use of nurses and pharmacists rather than just the doctors. The other thing, an interesting case management model, the general practitioners working in the mine hospital, were the case manager, they fulfilled the old traditional role, when they referred somebody to a specialist, they followed it up, there wasn't another nurse on some database and some things, they had those interactions, so I think it is a continuum of those.

If I have to pick one, nurses the proper use of a nurse and training them where it's needed, I think it was before the dispensing, the nurses dispensing regulations came in, but I mean the doctors controlled that very well.

DR BHENGU Would you say how we have used the prescribing nursing staff for the ARV programmes is sort of comparable in rolling out the changes?

10 **DR FOURIE** I will have to admit I don't know enough about the ARV programme to comment, but I assume so.

JUSTICE SANDILE NGCOBO Were they owned by the mines?

DR FOURIE Yes.

20 **JUSTICE SANDILE NGCOBO** And they were located at the mines?

DR FOURIE They were located, you see the precious metals were discovered where there weren't hospitals, so they had to build and also in the old days, of the inter-state agreements around the migrant labour system, that was part of the inter-

state agreement, that you will provide healthcare. So they built them, I mean Oppenheimer in Welkom was the biggest, at its height it had seven hundred beds, but they were owned, operated by the mines.

JUSTICE SANDILE NGCOBO And they were intended to treat the miners?

DR FOURIE Yes.

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JUSTICE SANDILE NGCOBO What about their families?

DR FOURIE The arrangements would vary a lot across. In the true old migrant system probably before 1990, the families weren't in close proximity to make use of this.

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JUSTICE SANDILE NGCOBO And this ensured that if the miners got ill, they will be treated in-house?

DR FOURIE Yes.

JUSTICE SANDILE NGCOBO By the doctors and the nurses employed by this?

DR FOURIE Correct.

JUSTICE SANDILE NGCOBO So it was a system that was designed to look after the miners, make sure that if, now how would you compare that to, I can
10 understand how useful, the whole notion of employing doctors and nurses if you own a hospital, which is designed to treat your own employees, but how does that advantage translate into the broader society?

DR FOURIE I think what has happened since about the mid 1990's is that there are far more families living in close proximity to the mines. If you go to the platinum environment, all 3 the big platinum producers have a more or less compulsory
20 medical scheme membership which the dependents joint. The services vary from how big and how complex your hospitals are, whether you do it yourself, or you buy in and so on, so I think they have evolved.

Perhaps I can answer it slightly differently, because given the mining industry had large concentrations of people in one spot, for those of you who know Pretoria and you go out to Rosslyn where all the car assemblers are, I can see a very good health facility in the middle, they all have occupational health services where a nurse sits twiddling her thumbs from 9:00 in the morning, they've highly qualified occupational medical practitioners visiting there and I can very easily see a health facility between Ford, Volkswagen, Mercedes in the centre that will probably take care of primary and a bit of secondary care with an association with the Medunsa facility, but then, you have to be free to design it efficiently in that environment, so I think the translation is a hospital controlled, but not centered care.

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The bulk of the care happens outside the mine hospital in clinics at the shafts and residential areas.

JUSTICE SANDILE NGCOBO I assume the rationale for setting up these hospitals at the mines, was to cut down on the cost of treating the miners. I can understand that model being used by the Government in order to cater for the uninsured and unemployed, but I don't understand how that can help the private sector, how, if that is being used by the private sector, that would have to cut down on the costs.

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DR FOURIE For any of those facilities to work, you need a concentration, a geographical concentration of the membership and if one starts developing, as I say, Rosslyn is an example, where groups of employers with Government and that's why I say we must think differently about PPP's, come together, the concept being that you have nurse clinicians that is first contact, well trained nurse clinicians first contact, you have employed doctors, you have, I said I am not going to say anything about NHI, I don't believe insurance is a good funding model for healthcare at all, so I think it is possible.

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It is not possible under current legislation, that's really my point. If you go to any of these situations and I know the mining areas very well, I mean what I'm going to do, have to put up in Witbank with the State to provide something of this nature, is very different from Rustenburg or the gold mining industry is a problem because of the economic circumstances, but it's a situational area, to say what make sense here, how can I do what Dr V did in [Aravid], how can I dramatically reduce the costs, provided for more people, because the simple reality is that we are not providing it for people. I mean the most measurable one is cataracts, it's a simple procedure. There are more cataracts created every year in South Africa than we operating. This pool of a quarter

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of a million is increasing. Now to my mind, that's the aim. Now we can either, try and back the public sector to be able to do that and that's what the NHI puts as its first service, but in the meantime, we can use the private sector with a proper regulatory environment to start providing that service, affordably and profitably.

I don't think we must try and duplicate the mine hospital system, but there are important principles that should be incorporated in delivery systems.

10 **JUSTICE SANDILE NGCOBO** Yes I understand.

DR BHENGU Ja Izak just the one line you said you don't think insurance is a good model for funding healthcare. Now I just want to be clear how broadly you're defining insurance.

DR FOURIE I think a pre-paid third party fee for service is about as inefficient as you can get, as the United States have proven and tinkling with that a little bit here

20 you know managed fee for service or whatever you want to call it, so to my mind, I think let's not confuse funding with insurance. When I refer to insurance, I mean the third party payer, largely fee for service because you know the asymmetry, the lack

of control, the over-servicing, the over-usage and anyone of us who sits in medical schemes, can point it out to you daily.

I mean I can show you daily on here's another case which wouldn't pass any academic scrutiny, but it's a PMB, the family insist, somebody must pay.

DR BHENGU No that's fine I get you, I just needed to be sure. You also said that we are looking at wrong international comparisons. I'm assuming of course among the favoured ones, are the ones you quoted for the hospitals in India, but which international models are wrong that you believe we are looking at?

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DR FOURIE As I've said to you in our discussions years ago, that I believe that you should develop the healthcare system with the need of the patient in mind and work out from there, the regulatory, the funding, the rest. I think we tend to come totally from the other side, from a conceptual funding model side, so I'm not sure I'm answering you, but to my mind, what I would like to do if I had the time, would be really to sit down and say [Aravant] and I've had enough contact with them, they will do it, let's get what the full costing you know of an [Aravant] hospital and the full costing system of a South African eye hospital. Then I think it will be obvious that the thing they do here, is not permitted by our regulatory environment, so etcetera,

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etcetera, rather than enter, I mean I've given up, I had lots of interaction with the Health Professions Council because of the mining industry and the employment of doctors, I've, given up.

We talk about, we're in different planets around that, so that is what I mean by or [Naruyanu] and the heart hospital is to say here's a guy who can do an open heart surgery for R50 000/R60 000 and in South Africa, it costs R300 000/R500 000. Now
10 go to a total costing, what are these guys doing that we're not doing and what are the impediments to that situation. I just come from an empirical environment, I like to say rather than have a big public debate, I can have the public debate, but I first want a bit more of those.

DR VAN GENT Good morning.

20 **DR FOURIE** Morning.

DR VAN GENT So what then is the iceberg here, is the, you were talking about the iceberg, because the iceberg here, that regulation does not [inaudible] so HSPC rules etcetera, etcetera, does not allow a fully efficient system to develop.

DR FOURIE Correct.

DR VAN GENT Right so if you took away let's wish ourselves in a new heaven we can draw up the new regulations ourselves.

DR FOURIE Ja.

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DR VAN GENT Would then and I refer now to your intervention on [inaudible] and I was noting that and I have similar notes on the events, why don't full efficient ARM system develop in the South African system? It is not because the current regulatory system prevents anything from developing, but it is something about the balance of powers through the funding industry.

20 **DR FOURIE** Agreed.

DR VAN GENT And I would like to talk to you about that later, but what is the real iceberg here is that the balance of powers and nobody is really interested in changing this balance of powers and changing the cost figures, or is it just a sort of

we're trapped in a regulatory system with a lot of self-interest etcetera, etcetera capabilities and that's where we are, we can't change it. What is it? Is it the balance of powers? The economic balance of powers, or is it the regulatory?

DR FOURIE I have no empirical reason for saying, I think it is probably towards the power side rather than we're just trapped in this. The other problem we have and this perhaps one of my issues around [Aravant], they have an organisation
10 [inaudible] international [Aravant] community ophthalmology centre which goes around the world assisting people to eliminate needless blindness, that's what they do and I've had quite a bit of interaction with them and the reason why we can't transplant that model simply, is we haven't got ophthalmologists, they are making too much money, to now go back into a salaried system, so I'm not sure what I've now said helps, but I think the fact that we have limited specialists making very good incomes, really have no interest in disturbing.

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The only thing that I would like to show in our project and it's just started so I can't say we are going to be successful, is to say can we, in your hospital at the margin, where you don't have to charge the full rate and we can get lenses, I mean [Aravant] lens costs $1. In South Africa, the same lens costs R3000. Now the guys are not

giving it to [Aravant], they're buying it, so I think there's a system. I mean if you look at the medical schemes and administrators and you've had lots of interaction of who's who in that activity, if my income is hitched to a notional 10% of contributions and contribution increases by CPI +1+2+3, all I have to do is sit back. Why would I rock it? So I do think there's for the little guys like us, we probably feel caught in this thing, but I think there is, it's thatch-lined.

There is just too many people who profit from the current order and it goes probably

10 from the GP's I think are the lesser culprits here. It goes from there upwards.

JUDGE NGCOBO Refer us to, which would back up what you've just said?

DR FOURIE Look I can certainly give you a lot of the [Aravant] stuff. There are small pieces that are confidential, because they still work in progress from our side, but I can certainly provide you know at least enough from [Aravant] to

20 understand and to my mind, show that it can be done, it can be done in a middle income country.

JUDGE NGCOBO [inaudible – audio too soft]

DR FOURIE I will try and get to it this week, I've just had 10 days leave and I haven't even looked at the mountain of emails, because I can't send somebody, I will have to do it myself.

10 **JUDGE NGCOBO** Yes.

DR FOURIE I will try and get it to you by the end of the week.

JUDGE NGCOBO Yes thank you.

DR BHENGU Still on the Indian [inaudible] comparisons, I think it's Netcare in looking at the regulatory side of things when presenting to us here, basically said the 20 regulations that have to do with setup of infrastructure in South Africa, imposes unnecessarily high costs, so right from the bat, you're supposed to put up a very costly structure which ultimately affects how cost effective your services are going to be.

Now would you say this is a significant issue in line, because when you gave us the comparison with the Indian hospitals, it was mainly more on the processes, but how would you recommend we look at the regulations that affect the setup of infrastructure such that we do not continue to insist on expensive infrastructure unnecessarily so?

DR FOURIE I think we need to probably take a step back. I'm a fairly
10 firm believer in supply induced demand in healthcare. I think it's a very real, as we've seen, so controlling the type and the number of hospital beds, I think is an important regulatory function, but it should be a transparent efficient system. I think when you talk about the private hospital groups and I have no real contact with Netcare of any nature, I think we all know the increase from 10 to how many private beds, I think thirty two thousand over the last fifteen years, I think is a huge contributor to this, so I think the regulation around that has been poor, so what do we
20 do? I own a share in sub-acute hospitals you try and get a license. You try and do whatever is necessary to get a license. We think we can make a case that we don't need high tech, we need care hospitals and so on, but you try and get that.

My view is that the delegation to the provinces, hasn't worked. One or two of the provinces are very efficient in this, but the bulk of them, are not and I think this is

one of the things that should be centralised, sickness are not provincial issues, they walk across borders and for anybody who has worked in the Free State like I have, you know you do half the Northern Cape and a little bit of the Eastern Cape and all that. I think we need a fundamental relook of the hospital stock in the country.

DR BHENGU But do you agree that there is scope to sort of reduce the requirements from the infrastructure side?

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DR FOURIE I probably don't know enough about the acute hospital, the large acute hospital from that perspective to answer you. What we don't need in South Africa, is a continued proliferation of super specialist hospitals. As I say, we have become and perhaps coming back to Dr van Gent's question, is you also get the consumer who wants to go to the eye hospital, he wants to go to the oncologist urologist, not the general practitioner, so I think to my mind, the granting of hospital licenses and Regulation 168, is quite onerous, but I'm not qualified to that.

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What I do think, is we haven't got a plan. There isn't a plan to say we need so many acute hospital beds here, so many sub-acute to rehab facilities, this is what we need you can apply for those licenses. What happens at the moment is a fairly haphazard response to an application. In other words, you know the hospital belt north of the

N1, is a prime example of that. It doesn't make sense, so perhaps I'm not answering your question. I don't think the problem is too tight a regulation, it is inefficiencies in the granting of licenses, but I think the fundamental thing is we haven't got a plan. We haven't got a plan and I think to my mind, as I said, I'm a very strong believer in supply induced demand in healthcare. If we are going to shift the resources to primary care and secondary care, we are not going to do that by building more open heart units and large oncology units and so on and so forth.

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DR BHENGU Just the last series of questions from me, I think part of your solution is really the approach if I understood you well, it is to say we can't bring about changes by tinkering at the margin to sort of go big, the Indian hospitals being one example. I want to look at practice now, clinical practice on a subject I'm certain you're quite familiar with, it's a subject that has come up a lot where everyone says it is usually in the angle of the HPCSA that we can't practice in an integrated fashion because of HPCSA rules and directly or indirectly, stakeholders propose the value

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based model on [inaudible] which I know you're familiar with.

What is your view about going this way in South Africa?

DR FOURIE I think if we had an epidemiological which we haven't got, but we've got lots of data, I would do simple calculations you know, is this doable for instance, we know that Mpumalanga has a public sector dentist with something like two hundred and fifty thousand people. That's the real problem. What must we do to get community dentistry services and what's the regulatory framework, start with the sick person, don't start with the professional or invest in a private hospital.

10 So if the way to treat people more efficiently is for us to set up in the industrial nodes treatment centres that does certain things, even if it doesn't solve every problem on a national basis, it is a helluva lot better than now, because currently now in my view South Africa is very simple. Eight and a bit million people get [inaudible – audio soft] then you get a middle group that buy primary healthcare out of pocket, that's probably okay and then you have I don't know forty million odd that are dependent on a fairly inefficient State system.

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Now that's the context. Now the State is trying to fix itself and we must support everything they do. I'm saying if you want to talk about the role of the private sector, must be not to become more and more elitist in this corner, but to spread this way,

but to be able to do that, you must radically reduce the cost of providing services and that's what we must look at. What must we do to allow radical reductions?
I have no doubt about the power of the groups and you know even somebody like GEMS who is a non-profit, I mean it's an important organisation, it has large staff, it has large contracts, it has all of that and I think within its own context, it has been very successful, but so perhaps that's why I'm saying we need.

10 **DR BHENGU**But within specialist practice outside of hospital, where are the 2 or 3 important touch points that we need to look at to achieve that reduction you are referring to?

DR FOURIE Look I think it depends on speciality to speciality. The oncologists in India practice [inaudible – audio soft] it's a paradigm shift saying you know how can I this eight and a half million people that's insured, how can I classify as a PMB and then go for it, because we see that all day, up-coding and it's natural. I
20 don't blame the people for it. It may not always be honest, but up-coding will always be with you in that environment, so making that little thing [inaudible – audio soft] perhaps that's when Sipho phoned me, I perhaps felt I should come and encourage you to be radical.

DR BHENGU No thank you very much.

PROF FONN DR FOURIE you have a unique perspective from 2 points of view that I want to try and understand better [inaudible]. The one is that you worked in the mine hospitals, but you were also a manager of for profit hospitals?

10 **DR FOURIE** Yes.

PROF FONN I understand from your CV?

DR FOURIE Yes.

PROF FONN And in that environment, how could doctors operate differently in those private hospitals and what could you as a manager do or not do

20 and just so I don't forget it, but I can come back to it later, was there any inducement or reason why you might in fact cooperate with them for a common goal that might be related to problems?

DR FOURIE You mean the specialist in the private hospitals?

PROF FONN Hmm.

DR FOURIE Probably not, as I said, I think and I haven't tested this, the only thing I've tested is with the eye guys, would you be willing to give us one afternoon a month at this rate to do cataract surgery, we will do all the admin, we will
10 biometric them, we will do all the admin, you just arrive and operate and they probably would say yes, but first thing they said, as long as I don't cannibalize my other practice.

So, to answer your question probably not, my experience and it is some time ago in the private hospital environment, is certainly that there is an effort to control over-servicing and all of that, but it's a very unconvincing and certainly very inefficient, or
20 the quality or any of those and that is why I'm saying the fact that they operate and they use it as an excuse on both sides, you know we are totally independent.

So if there is a problem with the doctor and you go to the hospital, they say but we actually have nothing to do with them. You can't say to them but you give me

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theatre time, they say ja but you know we can't, report him to the Health Professions Council or something like that. On the other hand, the doctor has no real interest in you know in practicing cost effectively, because he doesn't pay, it doesn't affect him and the margins is in the hospital's favour, so all the incentives are in the wrong place for cost effective good quality care, the structure is wrong.

How much do we have even where we're sitting now and we control quite a bit of the data of the private sector, or we have it, we don't control it, we have it. Even then, it is very difficult it is very, very difficult. We have attempted to profile specialists. I think it is starting to work, but many guys just say you know why would, I bother I'm as busy as I want to. If I work more, I just pay more tax, so I'm very happy doing what I'm doing, so a short answer, not a lot.

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PROF FONN So in your historical experience of working in the private hospitals, one of the arguments that we keep hearing, is that hospitals don't compete for patients, they compete for the specialists.

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DR FOURIE Correct.

PROF FONN And so how do they compete for specialists? What do they do?

DR FOURIE I think on the would be in facilities and expensive equipment and in my own life, I moved my practice, 3 of us, because [inaudible] Golding, the old Netcare's predecessor bought the first lithotripter, so we packed up at 3 places and went to Garden City where they installed in those days, a R9 million
10 stone machine just as an example around that, but I think the point that hospitals compete for specialists, is probably 80%-90% true.

PROF FONN So the one mechanism is them providing attractive equipment?

DR FOURIE Ja.

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PROF FONN Are there any other mechanisms to your knowledge?

DR FOURIE Look we wouldn't know. I certainly wouldn't know, I worked for Medi Clinic and I can state categorically that there were no other

incentives other than the equipment and the occasional golf game. Really, there was no other, but I can't exclude it from it you know.

PROF FONN And then you have also a life as working in the schemes and in sort of I'm a doctor, not an economist, but generally the person who has the money is the person in control and so the schemes have the money, but according to what you've said, they have no control, so what is it that schemes could or should do

10 and here I am particularly interested in the specialists, that they are not doing and why aren't they doing it?

DR FOURIE What, we are doing in the restricted scheme environment and I'm a big believer in restricted schemes, I think they are far more efficient than the open schemes, I think they suffer a bit from low common denominator and many of the schemes I work with, are geographically fairly concentrated and in those, we

20 have very tight preferred provider arrangements with the specialists.

The hospitals are more difficult because you have what I think Alex van der Heever termed this many years, the geographical monopolies of the private hospitals. If you go to Rustenburg, there are only 2 hospitals or if you go to many places, there is only

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1. So it becomes more and then you get people like the anaesthetist. The anaesthetists in my experience just ignore you, they just charge you, they just charge whatever and if you only pay this, they just go after the patient, so that power balance is much better in the restricted scheme environment.

None of them have the sort of pay scale upping that Discovery has where they pay certain specialists higher rates, but again, I think the scarcity and the power and the
10 other thing of course that one has to keep in mind with specialists, is that there are many longstanding doctor patient relationships and if you really want to upset a sixty five year old, is to say to him your cardiologist for the last twenty years is no longer on the panel and he happens to be the brother of the chief executive, so we certainly do better and if you look at the stats, you would see that the restricted membership schemes have, over the last 2 or 3 decades, performed much better than the open schemes, but it is limited.

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PROF FONN So just to make sure I understand you properly, you're saying that restricted schemes, because they're able to develop much clearer PPM's in comparison to Discovery, you said that Discovery are paying certain specialists more?

DR FOURIE Whether you're on the panel and I think they have 2 panels, I'm not, as I said, I'm not very and there is a rate per panel. If this is what you do, this is who sees you, you are not allowed to balance bill and so on, so they do that, but they have to cover the country. If I run for instance Impala Platinum's in-house medical scheme, I don't go beyond Rustenburg and 1 or 2 Pretoria hospitals, that's it, so I can control and I can direct and if the doctor is in my employment, then the issue of another specialist never comes up. In other words, you go and see and you must
10 go and see a cardiologist, they will arrange your appointment, so the issue of channeling happens in the system, not in the face of the individual patient.

PROF FONN So, the point I want to understand, is that the reason that Discovery has to pay them more, is because they won't come otherwise.

DR FOURIE They won't sign on.

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PROF FONN They won't sign on?

DR FOURIE Ja.

PROF FONN And so getting to the issue, so then it's the specialists who have all the power?

DR FOURIE I think that's largely true yes.

PROF FONN And is there in your mind, any mechanism to deal with that? You talk about radical reform, what is the mechanism to deal with that?

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DR FOURIE I skimmed over the tariff debate, tariff of course is one. I mean I do a lot of work in the Workmen's Compensation environment coming out of the mining industry, we have our own insurer in the mining industry called Old Mutual Insurance, where we pay a tariff, that's it, so if you want to do this work, that's the tariff. So tariff is probably the strongest one, but this is a Competition Commission, so in my view, the whole of South African, the Workmen's Compensation Commissioner who does the rest of the country, publishes a tariff. It is higher than the, whatever it's called nowadays the old National Health Reference Price List there is a tariff that he negotiates with the representative and that's it, the situation.

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That's probably the strongest and then that's what you may charge, you may not charge more and you must publish your results.

PROF FONN So you spoke about the profiling then of doctor's, because there's 2 things that the medical schemes have, they have the money which apparently they don't have too much, somehow the payer isn't king in this environment and then the other thing they have, is information.

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DR FOURIE Yes.

PROF FONN And the profiling, what you're calling profiling of doctors, but it's about results and outcomes I am assuming, it is beginning to work, so what system is that? Do you give doctors the individual results? Do you compare them to a norm? How could it work?

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DR FOURIE I think there are, first of all, the GP profiling is much more developed. They sign on to this and they get a profiling, both of their own costs and the actuaries assure me that they've risk rated the demographics and the disease profile of the patients and they then give them a result which compares them on a

type of peer. They also then have a little peer review committee that I think more or less looks at outliers, not at a whole lot of that.

I think again when you come to the specialists, it is difficult to profile because they do such different things, so I would tend to their profile hips and knees, urology, prostrates and radicals and a few procedures and what I think would be enormously useful, if we can take these, where you do it by day, where you do the critical 10 pathway of procedures and you start standardising them. I mean I think one of the big problems we have, is a lack of standardisation out there. Healthcare has become very, very standardised and protocol driven in that and yet, we give a guy a blank cheque and say fill it in.

So to my mind, I think if we are going to get without total disruption, an obligation to provide, sorry just on the profiling, you get very little and very unreliable outcomes, 20 clinical information. Where we do have clinical information, it's normally co-morbidities that we have on the system anyway, so there is very little, but any step in that direction, I think will be a hugely beneficial step.

PROF FONN Okay so, because what I'm trying to do, is put some specific content on your notion of radical intervention and so the one thing you're suggesting, is that the tariff system of some kind is an important one and then data re-reporting is another one.

DR FOURIE Yes.

10 **PROF FONN** And are there any other interventions that you think would, for example, let me give you one thing that I'm concerned about and that is the notion of the mandatory membership. Now, you make the point and that's an important one, that even if you had it, it's unaffordable. My concern about mandatory membership, one of the issues I turn around in my own mind, is that it's a blank cheque. If at this point, already, people are making as much as they can, they up-code, they make it a PMB and now they'll have more people, so that's my

20 concern about mandatory membership and you've already implied that there is a co-interest between hospitals and specialists, that the hospitals, if the specialists are doing more and keeping people there longer, the hospitals don't suffer from this outcome, so if you employ doctors and there's mandatory membership, it seems to me a blank cheque.

DR FOURIE Yes.

PROF FONN So what kinds of things could disrupt that?

DR FOURIE I confirm that the last thing we need is to put more poor people into the current system. I think that's all wrong and if we add a risk equalisation to that, it gets even worse, although theoretically it's nice, it gets worse, so that's the one component on this. To my mind, the and again, it is very difficult currently to develop critical pathways or protocols. I mean you know I was there myself, nobody is going to come and tell me how to do a prostatectomy, you just forget it. I have to buy in to the protocol. The comment has been made that private hospitals make more money out of bad medicine than out of good medicine. I mean it's not coming from me, it's fairly popular.

The only way to stop that in my view, is to force, the other thing in my view that goes with it, now I don't think it's going to make a huge difference, is of course the adverse incidents that don't get reported in the South African environment and if we believe any international literature, we must have our fair share of [inaudible], the

whole quality concept doesn't really, I mean the quality that we see, is the marketing quality.

We are the quality carers with the big machines and the nurses and that, it's not quality as meeting pre-determined standards of good care. I don't know whether I've helped, but I think there 2 things, I think the tariff gain must stop, somehow it must stop and the second one is if we report results and one can work out how to report. I
10 mean if we all need replacements, it gets reported this way, outcomes are international, no matter how much pain [inaudible] what flexibility and all that, we don't have to invent it, it's there.

PROF FONN Some of the other interventions around critical pathways and protocols has been for example, nice, those kinds of HTA.

20 **DR FOURIE** Look I think a nice concept for South Africa would be nice. There is no doubt that and again, they are changing the Medicine Control Council to health products something, something, something in this, but I think up to now, there is no economic evaluation for the registration of a new drug in South Africa. If they do it, it's because the pharmaceutical company wants to add it, not from a

compulsory basis, so I believe that in the private sector, there has been 1 or 2 attempts, I'm sure you've seen Johnny Brumberg, we've been friends forever and we tried to do that when he was still a health economist.

He used to say let's get, probably not as sophisticated as the Oregon league table, but let's get at least for new technologies and new drugs, this, because we are facing, like everybody else in the world, the flood of biologicals and if we don't do something in
10 that, I don't know, I see they use 4 times the income or something like that. I think that as an effective screener of new technology and drugs is essential and that must include an economic evaluation.

PROF FONN I've got 2 more questions. The one is in relation to what some people call task shifting, or what some people prefer to call task sharing, but certainly the notion of the experienced, well trained alternative to the specialist and
20 the doctor, so your nurse model is the one you are familiar with from the mines and then the Ministry of Health did introduce the notion of clinical associates which you believe these might have an option to bring down costs in South Africa.

DR FOURIE That's right absolutely and expand the, again the [Aravant] where they take a matric girl, they train them for a year and they give them fairly good equipment and it is digitally linked, so they examine the people and they show the results where these people come to 85% correct diagnosis and the other 15% gets done by that, so if you do that and you combine that with technology, we're not talking about sending a primary healthcare nurse with a bag of drugs into the rural environment. That's not what we're talking about, I think certainly people other than
10 the current registered practitioners and even those scope of practice and if need be, we join them.

Just on this, the nurse clinicians in the mining industry are certainly the one profession that has made the most. The second one is we used to see the same with the GP's, the doctors working in the mine hospitals, because they saw so much trauma, they were probably as good trauma surgeons as other people. Now with the
20 shrinkage of the mining, they are no longer there and I can see the effect on the cost, where these guys now go to the private hospitals, because the mine hospitals have closed or closed theatres or stuff like that. So I think it is across the board, it is not just the nursing.

PROF FONN So the last question and it relates to this one in some way, is some of the concern has been expressed, that we will have massive flight of doctors out of the country. Your raised eyebrows are not recorded.

DR FOURIE I saw a while ago, an article on the post 47 specialist movement out of the UK when Beveridge and [inaudible] were introduced. I don't know, my gut feel is that if the guys are going to leave, they are going to leave for
10 other reasons than this one, but I have no, the average specialist makes a very, very good living in South Africa, private practicing specialist and to pack up and go, it certainly there may be, I don't [inaudible] to continue with an unsustainable relatively inefficient system.

PROF FONN Thank you.

20 **DR FOURIE** I was a, urologist.

JUDGE NGCOBO Yes but you still have those qualifications don't you?

DR FOURIE Yes.

JUDGE NGCOBO Would you leave?

DR FOURIE South Africa?

JUDGE NGCOBO Ja.

10 **DR FOURIE** No.

JUDGE NGCOBO And the circumstances described by Professor Fonn?

DR FOURIE No look I nowadays view myself probably as something of a health economist manager, half an actuary and I think this is probably one of the most fascinating healthcare reform processes, hopefully it is orderly, that South
20 Africa has to go through. I mean I'm not making a political statement to say the current levels of inequality is not sustainable, it's simply not. I don't know if there is a [inaudible] co-efficient in health, but it must be enormous in South Africa and we're talking about 84%, so for me, I think this is going to be a fascinating thing to watch in the evenings after golf in the years to come.

JUDGE NGCOBO Thank you.

DR NKONKI Thank you for your interesting presentation, my question is on your statements around alternative reimbursement models. I see on the slide, you've put here your low-hanging fruit and of course alternative reimbursement models are not here.

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DR FOURIE No.

DR NKONKI Because as you've stated earlier on, that you think they will [inaudible] existing inefficiencies, I'd like to know if you think that that applies across the board, alternative reimbursement models for all different types of them and are you talking specifically to the ones for specialists, or this also applies to hospitals and the reason I ask, is that in the first sets of public hearings, we had the National Hospital Network come to present here and they talked about how they use different alternative reimbursement models as a cost reduction mechanism and their frustration with having administrators who negotiate for multiple medical schemes.

20

So I just first want to understand is your statement on alternative reimbursement models across the board, or is it specific?

DR FOURIE Well alternative reimbursement models have a lot [inaudible] properly applied, no question. I have a friend who is an activity based coster, he is doing his PHD in activity based costing, which is very interesting in this game situation, so one of the tools you must use, is an alternative reimbursement

10 [inaudible] I think is the point. There is also the little bit of wisdom which I always tell the people that alternative reimbursement [inaudible] because they disagree, where the schemes and the hospital group can't settle the issue eighteen months into the future, they still fighting about it now, then it becomes senseless.

You are already in the second year after and they haven't settled 2 years back in this, so I really meant it [inaudible] that I've seen in the South African private

20 environment, have not impressed me as doing anything more than entrenching [inaudible]. We start off where they have a nice distribution, a hip costs between this and this, we'll take 5% on the left and then we'll put carve outs on this and we've actually done and then they agree some increase limit on these and in theory, like many of these things look fine, they haven't worked.

In my book, they haven't worked in this and I don't know if Discovery, I was exposed [inaudible] of another administrator [inaudible] they certainly haven't worked to the extent that they are going to make a major difference to the cost in this. I think as I said to Dr Bhengu [inaudible] is a free choice, fee for service environment, so you must [inaudible] also when you do that, you must keep in mind that where over-servicing was your previous risk, you're now running to under-
10 servicing as your other risk.

So if you want to go into serious alternative reimbursement, you must [inaudible] have got internal, they've got internal quality improvement systems which I always forget, Stewart Whittaker started it, they have these systems that are around the nursing processes and all of that, but not clinical care. There isn't a publically available clinical care in any of the private hospitals that I'm aware of.

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DR NKONKI In your substantiating statement, you said they don't work well in the current system and you've encouraged us to think about radical fundamental and structural changes. Under what structural changes do you think they could work well?

DR FOURIE I think what one would have to do, because you will have to come up and say [inaudible] procedures, I think lend themselves to a mixture of a critical pathway protocol and an alternative reimbursement model, but you've got to get that thing together. So if we go and analyse the I don't know, the top fifty procedures in South Africa, we develop, the one thing those things do have, is they all have a halo effect, so once you introduce them, the influence is bigger than the, you know I believe a large part of managed care in the beginning, is a halo effect, 10 somebody is watching you, therefore I [inaudible] so to my mind, that would be one. Part of the tariff system, here is a tariff commission, develop, alternative reimbursement for the top fifty procedures over the next few years. That in itself, will have a dramatic effect on the private hospitals, because they will try and anticipate it and start doing it even before they come in, because now they know, so one would be if you have a tariff commission or tariff committee, is to start and develop a system of alternative reimbursements coupled with protocols and reporting, 20 I don't know.

DR NKONKI Last question is on the public private partnerships. You talked about how you think that having private wards within academic hospitals is not really for public private partnerships and so I wonder if you could give us

examples of how public private partnerships could work in the meantime as you explain the transition to the NHI?

DR FOURIE I will give an example which we're working on at the moment in the sub-acute environment. Kimberley for those who services the large hospital services the bulk of the Northern Cape, a huge area, sparsely populated and one of the big problems they have, is lag days. People come from two hundred
10 kilometers, have an operation and they leave the hospital when there's transport, not when they should leave the hospital, so they have lag days. Just down the road, is an unused, or a severely under-utilised rehabilitation sub-acute centre, not a paraplegic rehab, but below this.

We've put in a proposal to take that over, give them the beds they require currently for less money and we use the rest, because there are no sub-acute facilities in the
20 whole of Kimberley. They are building acute hospitals every time I go there a new one and we're saying we will run this. Now conservatively, it will take us 2 years to get approval to run it that way, provided the hospital license gets transferred and so on and so forth and the intention there, is one standard according to agreed nursing ratio's all of these. We can make it work, I mean the nurture that I referred to, they

are not charity organisations, they make money and here is a prime example where you can do it, but to get past the PPP, you are stuffed. For a seventy bed hospital, I mean I can't afford the lawyers to put in all of that, so I think there are again, we must make it simpler and I think we must give a lot of flexibility to make local solutions not necessarily some grand scheme, because healthcare delivery is a local issue.

10 So to my mind, I think we just need to put our minds to it and I think there are many areas, probably not in the acute hospitals, but in rehab, South Africa's physical rehab is not, I'm talking about the public sector Road Accident Fund situation, so I think there are many of those areas which if PPP's become simpler to the [inaudible] the people would do it. There is a dispensation of a service delivery agreement, but nobody can go into it, there is no guarantee of tenure and stuff there, so there are problems around it, but I think MEDUNSA and the car manufacturers is a prime one.

20 I can put a funding mechanism in, I can put the primary care in, I can use the nurse clinicians that are there, far more efficiently, I can get protocols in this, so it's all doable, but now I have to change 3 or 4 laws in that.

DR VAN GENT I won't go into the doctors in local competition, it is very interesting how [inaudible] and of course the position of doctors and regulations etcetera, but it is too much to cover. I am particularly interested in market power. Before I touch on that, I want to understand, so your solution, so you said, you want to stimulate us to think out of the box and to concentrate on the people, or maybe let's say the ten million people that's just underneath the insured population isn't it?

10 **DR FOURIE** Ja.

DR VAN GENT Who is going to pay, so it will not be the schemes that are paying for this particular group of people, it will also not be the Government because the Government is providing healthcare itself. Who is going to pay, provided we can organise it, set aside the rules?

20 **DR FOURIE** I think again, let me use the eye example, in hard terms, private sector cataract operation in South Africa, is somewhere between R17 000 and about R30 000. If we put not even the [Aravant] level, but something that is palatable to this, I open up in the employed we're probably looking at about R6000/R6500.

DR VAN GENT [inaudible] 20% or 30%?

DR FOURIE Ja and we have financial institutions that are geared towards term loans for this. In other words, I know I'm not addressing the indigent in this, there is a scheme in Bloemfontein amongst the farmers, where they actually pay the guys I think it's 3 days a year, where they pay R6000 and the group of

10 [inaudible] around it, so I think currently we have out of pocket and insured and or medical scheme and then a bit of a nebulous insurance dreaded disease type for the same people, it's not other people.

I think if we loosen that, but it's a bit of a chicken and egg, I can't go and sell it unless I have ophthalmologists signed up I have the assistants geared and trained, so that the guy really walks in and does his surgery.

20

DR VAN GENT Okay I think I get the picture. Coming back to the system within which we work here now and of course that is also part of our assignment, we can, look we have a broader mandate than just look at competition and competition solutions. Look at the eight and a half million people and there you said that's also

way too costly etcetera. I hope I quote you correctly, but your friend of ages Mr Brumberg doesn't agree with your approach, I will tell you precisely what he told us. I more or less quote him when he said that the hospitals, the quality of the hospitals in South Africa is top and the cost in absolute terms, is very comparable and acceptable, that's your good old friend Mr Brumberg, he doesn't agree with you at all. It's acceptable and comparable. Can you explain how the two of you with so much experience in the industry, can differ so much?

10

DR FOURIE I think he lives now in his current position at the top end of the eight and a half million insured and he compares his comparisons is about how does that compare to first world international standards and Discovery has a strong association with America. I'm concerned about this quarter of a million needlessly blind people, so to my mind, up to 2 years ago, we probably wouldn't have had, before I started being exposed to the Indian models in a full profit environment, have dropped the cost very dramatically, so I think [interjects]

20

DR VAN GENT Can I give you another possible explanation, or can I get your comments, because you showed us [inaudible] and [inaudible] says that Mr

Brumberg has actually [inaudible] because it is an interest, he makes a profit, he makes a living from this.

DR FOURIE Yes.

DR VAN GENT Would [inaudible] be the explanation, or your first explanation?

DR FOURIE Both.

10

DR VAN GENT Both, can you explain how, as I said I'm interested in market power and possible erosion of interruption of market power, so can, you explain where the balance of power at the moment, lies in between say Bonnitas, GEMS, Discovery, who are all 3 very different species of course and on the other hand, the hospital groups. One day, I tend to think it's on the one side and the other day I tend to think it's on the other side.

20

DR FOURIE I think the hospitals have created an environment of inflation plus tariff increase motivated by what do, you call it, Baumol's disease, which I think the Indians showed, is not true. If you use the same actors, it is true, but you must them differently or [interjects]

DR VAN GENT But your examples from India sorry, they are all specialised hospitals isn't it?

DR FOURIE They are all specialised hospitals, but why I think it's important, it's where our problem lies, specialists, hospitals, oncology. This is where the real pain and inflation in our lives lie, so they have done it and they've done it on a community basis. The [Aravant] internal funding model is fascinating. They don't
10 turn anybody away and they charge who can pay and because of their reputation, they see more and more paying patients. One system, one everything in that, so that's where I'm saying [inaudible] this type[inaudible] I think if to my mind as I said, I have an interest in insight, I started it, they don't allow me there operationally anymore, but I could make a big plea and show how important the actuaries is in the data-mongering in this process and I think they are important, but not in the current structure. For instance I would like to make them an arbiter in alternative reimbursements.
20

DR VAN GENT That is what I'm trying to get at, so you also use the metaphor of the iceberg underneath the ice and my first question to you, I say is that the regulatory context in which sort of creates a prism for us to think and step outside of

this prism and there I think we both agree there is another iceberg and maybe more important iceberg and that's the balance between the hospital groups, the funders and the doctors.

DR FOURIE I think to my mind, if I follow the circle this way around, the hospital who has the license, the facilities and all that, the doctor, the specialist needs that to work. Once established and an important earner in the hospital, that tends to change. The hospitals then in their annual negotiations with the funding committee, start off with the nurses' salary, you know the normal debate of why this should not be CPI but [inaudible and I think it's caught in that and in the meantime, they are all doing very nicely thank you.

10

The administrator takes 10% of something that grows. There's a nice study that the Minister always shows about the listed hospital groups and pharmaceuticals in South Africa as return on investment over a fifteen year period, which more or less outperforms everything on the South African stock exchange. So there is a big [inaudible] valley not to disturb this.

20

DR VAN GENT It is very important what you just said, so that the hospitals do their thing and there is also a connection between the fact that the negotiations at national level, are purely price based, there's no quality, the quality is set at a local level.

DR FOURIE Yes.

10 **DR VAN GENT** Let's see this as a fact and as a particular fact. There is no, quality [inaudible] negotiations at a national level. The question for me is then why is that? Why is that? The other question connected to that is, no let's first do this one, why is it that the hospitals do not, or the administrators do not succeed in talking about other issues and prices at a national level?

DR FOURIE Somewhere in the documentation, there was a piece on the agency and the failure of the agency role, I think there's an element of that.
20

DR VAN GENT Agent's role of who?

DR FOURIE Of the administrator, this is an administrator's job, it's not the schemes.

DR VAN GENT No, that's right.

DR FOURIE So by and large, I'm not very familiar on the GEMS tariff show, but the rest is you know Metropolitan Health negotiates on behalf of its

10 schemes, Discovery on behalf of its schemes, with 1 or 2 rare exceptions and so on, so it's the administrator in this, I think this is a nice system, I'm not going to radically disrupt it.

DR VAN GENT Both for the hospital and for the administrator?

DR FOURIE Yes.

20

DR VAN GENT But let me look at the administrator representing it's schemes. In a competitive environment, it would do its utmost for the scheme to have contracts with hospitals that are lower than other schemes, so the interest of the administrator from an [inaudible] perspective is, reduce cost as much as they can.

DR FOURIE Yes.

DR VAN GENT On the other hand of course and that's what you alluded to, it's also their interest to include [inaudible] as much as they can, because the 10% of the total mountain of costs that they sit on, they can put in their own pockets, so there are sort of 2 incentive structures that are [inaudible]

10 **DR FOURIE** Agreed.

DR VAN GENT So if competition was rife, the administrator was forced to choose the low cost, is there anything wrong in stating that if we see that at a national level, negotiators are not [inaudible] that sort of reveals to us that also the administrative market, the market doesn't really function.

20 **DR FOURIE** Ja I think that's true and let me try and come from a different side.

JUDGE NGCOBO What is the basis of this statement?

DR FOURIE I think as Dr van Gent described, we have [interjects]

JUDGE NGCOBO You are not testifying as an economist are you?

DR FOURIE The?

JUDGE NGCOBO As an economist, as a competition economist?

DR FOURIE No I think if we have to go to textbook competition, it falls
10 short and not for the normal reasons why a market fails in healthcare. I think the process fails, that's imminently true and again, I'm not exposed to a lot of that, but it is very concentrated and getting more concentrated as we go. The administrators are becoming fewer. The two big players are very dominant in numbers, but certainly, that structure is sub-optimal [inaudible]. What the administrators do do, is once this thing is in place, they have, oh yes, my hospital utilisation management saved you this, my pharmacy benefit management saved you that and so on, so they can all
20 justify to a lesser, they normally do the sums, present as this.

Also, it has become increasingly difficult for schemes to move, because people get into preferred provider networks or something, so it is quite disruptive and 10 or fifteen years ago, the schemes moved between administrators. Now we've had 2 big

schemes move, but before that, hardly anybody moved around this, so I don't think an administrator competes today by saying I've got a better tariff structure and quality management system and this and therefore, I will administer you. It is a whole lot of other things that I believe [interjects]

DR VAN GENT I'm also thinking of your reference a number of times to the Health Practitioners Council and the rules that prevents breakthrough innovations and

10 you have been involved and you have your experience in your engagements with the HPCA. What I'm surprised [inaudible] is that the rules haven't been challenged to my knowledge by large hospital groups.

DR FOURIE No they have.

DR VAN GENT They have?

20

DR FOURIE Ja but only for things like technologists. They haven't been challenged for practitioners.

DR VAN GENT And not on the challenging the position of vested interest of doctors. For example, the ethical rules that prevent a doctor to be employed by a hospital, could be challenged quite easily I think in the current legal context.

DR FOURIE We have from the mining industry side, challenged them and the only response up to now is that they went silent for the last 3 years.

DR VAN GENT Did you go to Court?

10

DR FOURIE No we said we don't accept this and you know your reason, because they can accredit you to do that in that undesirable practice. We went to the point of saying that we've now fulfilled everything that is reasonable in this, you must accredit this now and that's 3 years ago.

DR VAN GENT Why don't the big commercial organisations go to Court on this, because it is clearly written in the Medical Schemes Act, that the doctors can [inaudible] so any idea [inaudible]

20

DR FOURIE Can I perhaps just on the last while, I think the most important answer here is, if you look at disruption and disrupt theory, that's the last

thing that the [inaudible] and I think they will stop short of that and I think that's just the reality. It's a few players, a very comfortable environment. I think [inaudible] we also make our living out of it, so it's a very comfortable environment, the medical scheme private hospital administrator managed care situation and there is no real interest to disrupt, why would i?

DR VAN GENT On the license, you told us that we were, you used the words we were involved in seventeen licensing applications, who is we?

10

DR FOURIE Nurture Health, on the first slide, it's a group of sub-acute hospitals. We have 6 sub-acute hospitals, rehab centres, they are sort of stepdown, voluntary psychiatry and then we have rehab centres for paraplegics and major head injuries and that. The plan was, because there's very few of them, the plan was to establish a national network of those and we acquired funding, we have a very big BEE partner, we acquired funding from the National Empowerment Fund, but you need a license.

20

DR VAN GENT Can you tell us a bit more? You said that 2 succeeded and the others?

DR FOURIE The others are hanging.

DR VAN GENT They're hanging and then the youngest one is 3 years old and it is an enormous loss of money. Can you tell us a bit more about why and what
10 you do and how the reaction is?

DR FOURIE It differs from province to province, it's a provincial issue which is already to comprehend if you plan hospital stock. Then there is a formal application which in 1 or 2 cases, they lost, so we re-submitted 2/3 months later, what's happened, oh no, sorry can you resubmit. Re-submitted it, they will then visit your site, come and inspect that that's reasonable and right and everything else and
20 then they would spend anything up to 6 months and the standard response was one liner, not granted, you may appeal. Then you appeal and they acknowledge receipt of the appeal, but again nothing happens.

DR FOURIE (02:00:00) and the standard response was one liner not granted, you may appeal. Then your appeal, and they acknowledged appeal of the receipt but again nothing happens. And...

JUDGE NGCOBO This is the general?

DR FOURIE This is...

10

JUDGE NGCOBO The general procedure?

DR FOURIE Yes.

JUDGE NGCOBO Of all the provinces?

20 **DR FOURIE** No, I am scared to single out the provinces. Let me rather tell you where it works well even though we were not successful in the one. It works well in the Western Cape and the Free State. We haven't had administered the fund or joined in any of theirs. We went to the extent of looking at South Africa as a promotion of Administrative Justice Act. We went as far, but it is a small organization. It hasn't

got the means to do that. The subsequent hospitals are not high margin concerns. So what Nature has decided is that it will try and get a national food group because to do that properly especially when you want to work with the right funders you need a national food group. Is to work with the existing and try and consolidate a bit into the function. But very frustrating 2 – 3 years that I was involved in the license application. These are for the psychiatric rehab type facilities. Not Morningsides and Sandtons.

10

JUDGE NGCOBO Thank you. Nature, how many of these hospitals do you have?

DR FOURIE Six.

JUDGE NGCOBO And where are they located?

20

DR FOURIE Bloemfontein. Let us see where they are successful. Bloemfontein, Port Elizabeth, 2 in Bloemfontein, 2 in Cape Town, one in Umhlanga and one in... Six.

JUDGE NGCOBO And for how long have you been operating in your hospital?

: The people operate in them have been doing it for 10-12 years.

JUDGE NGCOBO Are you involved in any of the administration of any of these hospitals? What is your role in relation to these hospitals?

10

DR FOURIE The role in relation was that we put the commercial structure together to roll out the national network of rehab centers. So we were the people with my BEE partners. We were the people who put together, we using now just one. Long established people that run these rehab centers. They have been in the business for fifteen years. They do all the administration. Well put it bluntly I attend quarterly board meetings now. When we were doing the hospitals I was far more involved because there is a certificate of need that you must prove. And I went to speak to the Doctors and we used the database we had to see what kind of work the hospital does. So I was far more involved with the technical aspects of license applications. That is why I probably since my frustration from the man preparing the hospital, sorry the licensing.

20

JUDGE NGCOBO Okay, you do not take part in the negotiation for the tariffs. Do you?

DR FOURIE No.

JUDGE NGCOBO You do not take part in the recruitment of Specialists, do you?

10

DR FOURIE Those hospitals do not. What we have in the rehab especially paraplegic is of course a rehab team.

JUDGE NGCOBO So you do not take part in the recruitment?

20

DR FOURIE No, not at all. I literally to quarterly board meetings or if there is a specific issue. I am the only medically qualified person on the board.

JUDGE NGCOBO The statement that Specialists have power, what is the basis of this statement?

DR FOURIE Let me, because I think there are a few dimensions to that. The biggest one is let's say I am a very successful neurologist or pedic surgeon or what have you. I Doctor...

JUDGE NGCOBO Doctor Fourie I understand that. I just want to understand what is the basis of the information that you are giving us. Is it out of your own personal knowledge as a neurologist or do you have your acquired knowledge
10 through some other means?

DR FOURIE I think it is my experience as a neurologist and as a private hospital Manager and interacting with Specialist in private hospital from a funder perspective.

JUDGE NGCOBO You practices as a neurologist in, is it 1980 – 1988?

20 **DR FOURIE** 81 to 1997.

JUDGE NGCOBO 88, according to your CV.

DR FOURIE Yah.

JUDGE NGCOBO And you were a Manager of Medi-clinics for two years isn't it?

DR FOURIE Yes.

10 **JUDGE NGCOBO** And then you have been involved with the medical scheme for at least 11 years.

DR FOURIE Or seems there because remember the mining industry has significant medical schemes as well.

JUDGE NGCOBO Yes, the mining industry. I think what the views that you are expressing here at least speaking for myself I need to understand what is the basis 20 of this statement that you are making? Do you understand that?

DR FOURIE Yah, all I can (interrupted)

JUDGE NGCOBO I mean as a Specialist?

DR FOURIE I experienced it as a Specialist 1st hand. I was the only Specialist in South Africa that could operate the ... I taught the others and if I wanted a specific nurse to do all my theatre work, that is what I got. And if I wanted to go for a training course which was necessary I went to Siemens headquarters.

10 **JUDGE NGCOBO** Perhaps you should tell you what exactly do you mean when you say Specialists have got power? What are you talking about?

DR FOURIE It is the private hospital this is the guy that generates the money. The patients do not go to Sandton Clinic. They go to see Doctor x, y, and z because he has a good reputation or he is a super Specialist in knees or whatever. So they draw, the patients are not; they are geographical. If you want your tonsils out and that Doctor controls.

20

JUDGE NGCOBO Perhaps to understand this, why don't you relate this to your experience as a neurologist. How did that happen, that is between the years

1981 to 1988? How did that market work? How did that power you are talking about play out?

DR FOURIE Look it was a unique environment because we were the first and for about 2 and half years the only ... shockwaves and there was a guy who was trained. I never received money or Commission other than my fees but on the day to day... listen; all the other people in the country were on it. I went onto two International training courses on this which I can't remember today Netcare today or clinical holdings of those days or Siemens who owned the machines paid. I can't really remember and I have a very competent Dutch theatre Sister. But she worked for other people and from that day I said no, she will only work from here. So I think that is the kind of thing I referred to.

10

JUDGE NGCOBO You were based in Durban and in Johannesburg?

20

DR FOURIE Yah.

JUDGE NGCOBO Where you attached to any specific hospitals?

DR FOURIE: Yes.

JUDGE NGCOBO Which hospitals?

DR FOURIE: I worked in Durban at Parklands and in Johannesburg 1st at Sandton Clinic and then at...

10 **JUDGE NGCOBO** And then what power did you have when you worked for these? Is it Parklands hospital in Durban and in Johannesburg?

DR FOURIE In Parklands we were 4 neurologists of which I was by far the youngest. So I operated in the system but we were very important part of Parklands. We had our own ward, our own staff. So as I said that is you have a big influence. 1st of all the hospital does you a favor by creating the facilities and buying the equipment and then it goes to a point when you are now the guy who keeps this 20 going. And to that extent you are powerful because you can move your practice to another hospital.

JUDGE NGCOBO And then did the hospital give you an incentive to make sure that you do not move?

DR FOURIE There was never offered and I didn't receive. I can't tell you whether other people did or didn't do. I think my chauvinistic face probably stopped them from...

JUDGE NGCOBO Was there any occasion were you made use of this power that you described?

10

DR FOURIE As I said yah, my ward, my staff and dedicated theatre system and that was granted. But I never used it certainly for any commercial gain.

JUDGE NGCOBO I understand.

20

DR FOURIE I was never offered. I can't comment on whether it is or was common practice.

JUDGE NGCOBO I understand. Now you were the Manager of the Sandton... clinics which was in 1998 and 1990 I think it is.

DR FOURIE Yah.

JUDGE NGCOBO Now where you ever involved in tariff negotiations?

10 **DR FOURIE** No, Not at all.

JUDGE NGCOBO Where you involved in getting specialists to come and work in these clinics?

R FOURIE Yes, we Morningside at that stage was a major open heart and it was largely built around one particular famous Specialist pediatric cardiologist surgeon and that there was 7 cardiologists that came and it was relatively new. It was
20 2 years open. So I spent a lot, I paid a lot of attention.

JUDGE NGCOBO Where you involved in recruiting Specialists to come and work from this?

DR FOURIE Not in a major way but certainly, I do not know. Probably in the two or three or four, the bulk was there.

JUDGE NGCOBO I understand, but what I want to know is did you take part
10 during your stint at these two hospitals and clinic take part in recruiting Specialists to come? How did you do that? Did you offer them anything to come to the hospital? What did you offer to them?

DR FOURIE I offered them rooms at standard rate, there was a standard rate at that stage at Morningside. I offered them... (inaudible)

20 **JUDGE NGCOBO** So you made them the same sort of offer that any other hospital would have offered them. At the time where were they?

DR FOURIE Sorry

JUDGE NGCOBO Where were they, where were these Specialists?

DR FOURIE One or two of them had qualified but was still working full time in the States. And the others were at the time pre-1990, a large part of the Johannesburg Specialist Community was close to the Center, Parklane, Brenthurst and that.

10 **JUDGE NGCOBO** Yah.

DR FOURIE: Next to Hillbrow. And the area became less and less group for specialists. So we had a normal migration north for specialists. So it wasn't especially Morningside. Sandton was more of a general hospital. Morningside we had no problem recruiting what we felt were some of the top knee, back orthopedic and then cardio. Those were the two big... but now they are all over.

20

JUDGE NGCOBO But the fact of the matter is that you did not offer anything that the others could not offer to those Specialists who at the time were attached to your hospital. Is that right?

DR FOURIE Yes, that was also I can absolutely say the Medi-clinic policy. No other incentives paid other than what I have described.

JUDGE NGCOBO You are aware that others have been offered shareholding in hospitals?

DR FOURIE I am aware of that but I was never involved on that.

10

JUDGE NGCOBO Are you aware that some of them have been offered subsidized rooms at these hospital?

DR FOURIE If you are asking for the evidence I probably can't but the short answer is it is not an uncommon practice.

20 **JUDGE NGCOBO** Okay, and then you were intimately; that is what you say in your CV. You were involved in the establishment and registration of the mining and non-mining industry restricted membership medical scheme. It was 1997 to 2016. Are you still doing that now?

DR FOURIE Yes.

JUDGE NGCOBO Okay, are you involved in tariff negotiations of this medical scheme?

DR FOURIE Not at all.

10 **JUDGE NGCOBO** Okay, what is your role?

DR FOURIE My role is a combination normally is to advice the board of trusties on the governance management structure and the appointment of the Administrator which happens once in 10 years. Then I quite often Chair the clinical committee. I do not give clinical opinions; I am too far away. I Chair the Clinical Committee of the Schemes, reporting to in all cases I report to the board of trustees.

20

JUDGE NGCOBO Where you also involved on the Management and administration of the schemes.

DR FOURIE No, other than to provide oversight of the committee that it is done you know. In other words, if they appoint an manage care organization. I will look at the program...and all that. So I would advise the board on this.

JUDGE NGCOBO Then your CV must be misleading because it says here "Intimately involved with the establishment, registration, governance, management and administration of new members mining and non-mining restricted"

10

DR FOURIE The first part is I can give you the list of schemes I registered.

JUDGE NGCOBO Okay, and the administration part?

DR FOURIE I do not go as far as actively but I oversee the administrative; it depends on the competency of the board what role you play. There are boards which are highly competent and there are boards for local reasons may come to board meetings once a quarter. Then your roll is to make sure that the reporting is done properly and the documentation is done properly and so on.

20

JUDGE NGCOBO Do these schemes have designated service providers?

DR FOURIE Yes, most of them.

JUDGE NGCOBO How do you decide to designate as a service provider?

DR FOURIE You, healthcare never happens from a ... So you start of by looking at natural usage. In other words, you see that this scheme 80% of the orthopedic surgeries done by guys in practice at a certain price. You do not want to
10 go and disrupt that. So you start off with natural usage, then you draw up they are fairly standard; there is nothing on the rules, what will you give, what information will you provide, what tariff would you charge, are you allowed to balance the bill and in what circumstances can you balance the bill, can you give us cover over weekends and holidays?

I was in contact with one of the orthopedic surgeons in Krugersdorp and he is on
20 leave. So there is the standard stuff that you do in those. But you will start off with and to some extent and I know it is not scientific we also have a very good idea of who are the guys that will fit this sculpture because in all the schemes that I am involved in is the schemes managed care involvement in all the service providers are fairly; I always say it is a context thing. They are far more aggressive in their PPMs

because they can shift, they can move the membership. It is very difficult for the large open schemes. So on this but I am probably creating a wrong impression. You start a scheme, what happened in 96 was a very large mining industry scheme called Miners Benefit Society went belly up. the mining houses then cut it up then took their own and their own pensions out. So I mean just mentioned, for Anglo-Gold, for Goldfields, for Impala, for Anglo Plates and for... I mean all those schemes I wrote the rules. Submitted this, drew up the business plan with the help of the add tariffs

10

and submitted this to the Council. And I think what I do nowadays is remember in mining the medical scheme world is important but there are other healthcare outsiders.

It is very onerous occupational health, safety, hygiene they all run HIV/AIDS programs. So what I do is keep perspective. I keep these things in balance without getting in too deep into any of them.

20

JUDGE NGCOBO How transparent is the process of identifying the designated service providers?

DR FOURIE In the things I am involved in.

JUDGE NGCOBO Yah.

DR FOURIE It is not an open tender, in other words we do not put out a thing. I think what we would normally do is to say you know Doctor X, we have noticed that you have been treating lot of our patients. We would like to register you as a
10 preferred provider with direct payment and all the other advantages. But these are what we need from you. So it is very seldom that we throw out something and say here is ten rand ... normally it is developing the relationship and in the end you know Doctors are like all trade unions, they like to talk to each other. So I would help initiate that but I do not do it on a day to day basis.

JUDGE NGCOBO Okay and then you talked about the mining industry and
20 how they receive treatment. What about the miners, what happens when they leave the mines?

DR FOURIE If they are on a medical scheme, they have the same statutory right as anybody else to remain on the medical scheme.

JUDGE NGCOBO Okay, so the mining companies in addition to creating these hospitals, they also have medical schemes offers which they use to go to these hospitals.

DR FOURIE Mostly but not exclusively, also historically remember pre-1994 the medical schemes in the mining industry was racially segregated. Those things were really medical schemes that we call category 9 and above and mine hospital
10 with or without the medical scheme ... that has changed dramatically. But the three platinum (interrupted)

JUDGE NGCOBO The change is in relation to those who are now retired?

DR FOURIE: Yah.

20 **JUDGE NGCOBO** But what about those who left the mines prior to 94? Did they have medical aid?

DR FOURIE No, the majority of them would not be. They would have to rely on ... health system in the labor sources.

JUDGE NGCOBO And some of them had to ...what was recorded I the media had contracted silicosis. Is that right?

DR FOURIE I haven't put it on my CV but I'm the Senior Advisor to the mining companies. I am trying to solve that problem. One, because it is run by the Occupational Diseases and Mines Act; it is administered by the department of health

10 and there has been huge problems. There are probably, it is in the Media between 200 000-400 000 uncompensated for which we have the money but we can't find them. that is the one problem. The second problem is the compensation for occupational injuries and diseases has a much better benefits. So what we are doing at the moment is trying to amalgamate those two statutes. It's not easy because they have very different systems from assessing disability and all of that.

20 **JUDGE NGCOBO** What about continuing medical attention to those who might have contracted silicosis?

DR FOURIE Silicosis or other occupational diseases or injuries.

JUDGE NGCOBO Yes. What happens to those?

DR FOURIE Injuries have where there is a lifelong need that is handled by under the Compensation of Diseases Act by Old Mutual. Life-long, sorry the Commissioner across licensed on his behalf, he makes the rules. In other words, paraplegics, major amputees, all of those have got lifelong medical care.

10 **JUDGE NGCOBO** Will those cover those who left the mines without medical aid?

DOCTOR FOURIE: Yes, absolutely.

JUDGE NGCOBO Okay, so in a situation where those who left the mining companies without medical aid are fully covered?

20

DR FOURIE For occupational injuries and diseases except occupational diseases... which covers six lung diseases and it has a totally irrational provision for medical aid. So the defector situation is that those people have to rely on the public

sector in labor source areas which includes Lesotho, former Transkei right up to the 17th parallel in Malawi.

JUDGE NGCOBO Looking at your experiences in the mines, is there anything that you may want to have improved within the mining industry in as far as medical schemes are concerned?

10 **DR FOURIE** I think we are done. I think we are very successful in taking the bankrupt scheme, breaking it up. this is where my great belief in local rules for local shows. If you take for instance the three major platinum producers in Anglo Plats, they have fundamentally different arrangements depending on the size and the capabilities of the hospitals and so on. So either the mining industry's health care system given the severe shrinkage in numbers. Because health care is a numbers game you want to run a hospital you need lots of people given the last from the real shrinkage started in 95 and 96. Just think yourself you have a workforce that you

20 look after that more than half in a decade. You have a platinum price that goes from three thousand dollars to less than a thousand dollars in four years. So it is a rather easy place to operate but I think very successfully and your neighbor across, the

DMR is an extremely vigilant watchdog of health under the Mine Health and Safety Act.

JUDGE NGCOBO Now the other statement that you made is controlling the number of beds is an important regulatory mechanism.

DR FOURIE No, I think there must be a strategic review of the South African
10 hospitals.

JUDGE NGCOBO Yes, what do you mean by that?

DR FOURIE That means we, somebody has to go and start off. What do we realistically need in South Africa to provide affordable miner... so if you go to a hospital it is put more CAT Scans that will be used. So supply side regulation is
20 important. The current way they are doing it seems like an unspoken moratorium and it makes no sense. It must be in my view a transparent, they must get clever people like yourselves to say review the hospital stock in South Africa and come up with a ten year plan on how you think this should be done. One of them is to perhaps limit the number of private beds but that must be dictated by the facts on the table. I am

absolutely convinced that they can give me one or two of my rehab hospitals quite sensibly to look after rehab. So I am not saying just limit the beds I am saying have a plan, which I do not see at the moment.

JUDGE NGCOBO Yes, thank you. Is there anything that you want to address to what you have told us. Thank you.

10 **Drs Van Gent** You have told us Doctor Fourie that it is not about competition, it is maybe about empowering the patient and the number of the scheme. And you have told us you are chairing some of the boards to the schemes. You are a Chairperson.

DR FOURIE No, I am the Advisor.

Drs Van Gent You are the Advisor of these boards.

20

DR FOURIE No voting power.

Drs Van Gent You are an Advisor of the clinical boards?

DOCTOR FOURIE: I am an Advisor to the board of governance and contracting and ...

Drs Van Gent What did you say about the clinical boards?

DR FOURIE The medical schemes quite often have a clinical committee and they look at the... and things like that.

10

Drs Van Gent Right, so we have evidence in one of the earlier submissions in the hearings where the clinical committee of the rules...is that possible in your view?

DR FOURIE: It is probably possible and all you can do is refuse to pay. In other words, yah I mean from that perspective what I do is if there is a care problem either with negligence or otherwise. I will take it and contact the attending Doctor. And say look, these are our concerns, can you give us the information on these concerns. We,

20

I am just trying to think I probably have a meeting with one of those schemes of clinic committee.

PANEL MEMBER Or as Doctors?

DR FOURIE I refuse to be there in case there is a ... because I have been ... what we would do is try and work with the Doctor given the rules of the... you know there are... even though you may think so. What we would do occasionally is to say this scheme does not fund dental implants. It can't afford it unless there are very specific certain guidelines that you would follow. But it wouldn't go and interfere with the... we probably do not use 2nd opinions more than one or two a year.

10

JUSTICE SANDILE NGCOBO And on the basis of the declining of the payment?

DR FOURIE We running into progressive problems in oncology. That is where the big problem arises. Where there are limits and there are designated providers and the expensive area.

20

JUSTICE SANDILE NGCOBO Do you think in your professional opinion; it is possible for a clinical committing to overrule the treatment by Doctors without seeing the patient?

DR FOURIE They shouldn't do. What they could do is interpret the rules of the clinic of this... and say according to the rules his scheme they will not pay for this.

JUSTICE SANDILE NGCOBO The scheme rules?

DR FOURIE The scheme rules or guidelines provided by the board. A lot of the staff are people who have involuntarily use on none PPPs. If you were told there was a core payment you use a non PPP otherwise the system fails.

10

Drs Van Gent You have never had a, it turned out the payment for a treatment and the treating Doctor ... and then you report to the board of trustees... There has never been a situation where you disagreed with the patient and the patient appealed to the scheme?

DR FOURIE: Yes, there is a very easy appeal mechanism, sometimes a bit too easy for patients who disagree first of all to the scheme itself which we take to the board

20

and secondly to the Council

Drs Van Gent The Council of Medical Schemes?

DR FOURIE Yes.

Drs Van Gent Also the HPC as well might be involved.

DR FOURIE They are not really involved.

DRS VAN GENT A patient might consider applying to the HPC on the fact that you
10 two Doctors decided otherwise on the treating of the patient. Would you reveal the identity of the Doctor? Your own identity and your colleague?

DRS VAN GENT You would?

DR FOURIE Yes, there is no hypocrisy

DRS VAN GENT Thank you very much. Is there anything else that you would like
20 to address to what you have just told us?

DR FOURIE No.

JUSTICE SANDILE NGCOBO Thank you Doctor Fourie for coming to share with us your experience and in particular what needs to be done in the meantime you will be setting out in the...

DR FOURIE Thank you, good luck.

JUDGE NGCOBO I think it will be helpful if at some point you could give consideration to some of these issues that you have put up here because my impression is that you have not carefully considered some of these options and the extent to which they may apply and what are the pitfalls in applying them.

10

DR FOURIE I fully agree.

JUDGE NGCOBO Yes, because you do have an experience in regard to what you have done over the years. It does seem to me that you can provide such a youthful insight. But also speaking for myself I will be interested in the results of the exercise that you are currently involved with your partners in media. Just to get a sense of the results to the extent you could cut down on the beds.

20

DR FOURIE As soon as they are results that I can share, I will obviously I have to tread very carefully.

JUDGE NGCOBO Oh, well we understand that.

DR FOURIE Especially with my friend the entomologist, he is reluctant. Something that it is primarily that they would want to publish because then they guy who is
10 paying ...is going to complain. We would have had this off the ground had it not been for that ... which I think it is inevitable once we start. But anyway you are welcome.

DR NGCOBO Yes thank you.

DOCTOR FOURIE Thank you very much.

20 **JUDGE NGCOBO** Thank you very much Doctor Fourie, thank you so much indeed. Is Mr. Stephen Laufer here. Please come forward please, thank you. Once you are ready to roll you will signal. How do you pronounce your surname?

MR. STEPHEN LAUFER Laufer.

JUDGE NGCOBO Laufer, thank you. Mr. Laufer thank you for coming to share with us your experiences. You have provided us a nine-page statement which sets out the experiences you have had with your medical aid scheme. Is that right?

MR. STEPHEN LAUFER: Yes, I did and I apologize for the delay in getting it...

10

JUDGE NGCOBO Yes, thank you for making this statement available to us. I think you can approach the matter on the footing that we have read your statement and that we are familiar with it. But you are a strategic communication, media relations public affairs advisor operating both in South Africa and Internationally. Is that right?

MR STEPHEN LAUFER That is correct.

20

JUDGE NGCOBO Indeed, and you are a journalist in your prior life? ... which means that my training took place.

JUDGE NGCOBO Yes, indeed very well. Do you want to talk to us about your experience?

MR. STEPHEN LAUFER I think that the statement is fairly clear on two fronts.

JUDGE NGCOBO I wonder if you can get closer to the mic so that you are on record. You are not talking to us off the record.

10

MR. STEPHEN LAUFER: Yes, very well. I suppose what I was saying is that I approached this from two areas. I was fascinated seating at the back Discovery come up in the previous discussion and the question as to whether to make ... evaluations or a higher calling. I cannot make that call of course. I can only speak subjectively from my point of view. And my experience of Discovery has had its distressing moments throughout my membership in the years. I realize that in the grand scheme of things in South Africa mine is a real luxury. I am well insured, I am well cared for, I have access to very good doctors in very good hospitals and so on in which many people don't yet. But I think that the issue is really about ho costs are managed and at which end. And my strong and growing sense is that Discovery makes life very easy for themselves by trying to manage the cost issues at the expense of the member or

20

patient rather than a terrain that might be more challenging which is hospitals and Doctors and managing those costs. Perhaps at the pharmacy level and if we take the pharmacy's story for example. We have ... yah, my local pharmacy from a range of reasons from easy access, from my subjective point of view less stress in using it. And it also occurs to me that it is a community pharmacy which serves not only public participation who can afford that gap.

10 It is a Community Pharmacy used by a lot of domestic workers and their children for example who do not have the time or ability to get to a big shopping mall where there is a pharmacy that belongs to a big chain which Discovery has negotiated lower prices. And I suppose the issue here is so are they making it easy for themselves by negotiating with the big chain where you seat down with two or three of the big chains and you have done your job in cost management and the pharmaceutical side rather than the difficulty of managing a host of relationships with smaller pharmacies where you might be able to work out lower rates with them too. You know it seems
20 to me the benefit of cost effective approach to all of this is always to Discovery's advantage. And they make life pretty easy for themselves. So that is the one side of it, in the long-term side of it. And I have given you some figures in my submission. All of them drawn from Discovery documentation to me. So they send out each year a

piece of paper which says you can use this for your tax return. This is what you have paid us in contributions and this is what we didn't pay for. And as I said there what is fascinating to me is how the size of what they haven't paid for has risen fairly significantly in the last 3 years.

The other side of it is the particular experience last year when I was travelling in Germany and I needed as an emergency really an angiogram. And the battle we tried
10 to... the submission. Which you know given my professional background I am used to fighting my way through to the boss if I want to talk to the Boss and get a quote on record and so on. I am fairly tenacious and I am sure many people have not as tenacious as I am. If I think for example of you know an older aunt of mine. She would never had seen that thing through. And I think those are some of the issues I wanted to raise really.

20 **JUDGE NGCOBO** And you have described yourself as tenacious. ...the quote that you want. I suppose there is a basic question that one must as and that is what makes a person like you who has had the kind of experience that you have described in your statement to continue to hang around. What is it that glues you to this skill? ...tell us about these schemes.

MR. STEPHEN LAUFER I think that is a very interesting question thank you and one which I recently discussed with my neighbor who is a Doctor and who self-insures. And we essentially came to the conclusion that my error was joining Discovery 15 years ago. If I had self-insured in those 15 years, then essentially I would have had half a million rands and more to invest over that time. Even if it had been very prudent money market investment of 6 and a half percent. I would be way ahead today and armed and ready for those illnesses that tend to show themselves in old age. I am a prisoner of Discovery at this stage. Having paid them what I paid them I can't now essentially leave because if I do and let say I need expensive cancer therapy then I am done for. But if I had looked after myself in the last fifteen years; that part of the money will be available.

As I said I am a ... and not an economist so I am sure there are others who can do the figures on the actuaries in a different way. But certainly what I would have removed from the equation in the last 15 years is Discovery holding this portion of everything that I have paid for in terms of their management fee of the scheme and in terms of their need to justify raising share process and share prices. And as your previously

witness noted the share prices has done very well in recent years. I can't shake the sense that share prices have done well at the expense of the insured.

JUDGE NGCOBO You say, but this have to do with fear of being uninsured and fear of losing the benefit that you might have if you were to walk out?

MR. STEPHEN LAUFER I think at this stage it is simply about an investment that has already been made. It would mean walking out on a large investment. I am 62, I have a couple of heart issues as you know from the submission. The possibility that there will be further issues as I get older is not completely excluded. And therefore to walk out on an investment like that will perhaps be silly.

10

JUDGE NGCOBO And then what is the solution here?

MR. STEPHEN LAUFER What is the solution?

20

JUDGE NGCOBO Yes, I mean one thing we know from what you are telling us is walking out is not an option. What are the alternatives?

MR. STEPHEN LAUFER I have thought about it and I am very hesitant to be presenting to a panel that has gathered expertise that your panel has. I think it is one of the mistakes journalists often make is to come with solutions. I think I would feel differently if the contribution that I have made given my earnings potential was going to pay generally more equitable health systems across the board. And I know that is easier said than done. But I have lived for many years for example in Germany where costs have also been an issue but have been managed differently and the public health
10 system is available essentially to everybody and it is a good public health system. And I think that given my background that would be what I would rather be contributing to.

JUDGE NGCOBO: Thank you, I have interrupted you. I think that is the question that was bothering me when I was reading your submission. I kept on asking myself why not leave?

20

MR. STEPHEN LAUFER Too late basically.

JUDGE NGCOBO: I understand, I mean is there anything you said you wanted to...

MR. STEPHEN LAUFER I am happy that you have read the submission. And if there is a question from...

JUDGE NGCOBO I think we are going to, my colleagues are going to ask questions.

Dr Bhengu Mr. Laufer, based on your experiences now over the 15yrs you have
10 been a member. What advice would you give your ...based on your unhappiness now who wants to join Discovery.

MR. STEPHEN LAUFER I think that is a very difficult question to answer because over the years I have spoken to insurance brokers and others to say is there not a different scheme that may be more transparent in terms of what they are charging for and what I am getting. And B, where I would not have a sense that ...my time
20 managing this situation. And the answer has always been Discovery has always been the best of the bad medical schemes.

So I think one is caught because as your target of your enquiry says we are in the market situation. Rather than one which perhaps started off from a different premise.

And that different premise might be to say our endeavor is to provide as good health care for everybody as possible, as transparently and as simply and so on as possible.

DR BHENGU So is the issue more with Discovery or more with the health insurance medical schemes market and how it works?

MR. STEPHEN LAUFER I do not really have huge experience with the other
10 service providers, so I do not really think that I am qualified to comment on that. My one has been a specific experience and you know what I haven't included in my submission for example is a variety of efforts are made in the early years to get things ... with Discovery. And that included long telephone calls with the call centers. Sometimes identifying someone who is really helpful and helpful for a while and then disappear and then you have to start the process again. Particularly around the issue of travelling and getting medication. Long term medication ... ahead of travel.
20 And I finally gave it up and that is part of the reason why I have a relationship with my local pharmacy because they give...

DR BHENGU Just picking up on the Judge's question I have also noticed that my 1st question you did not say you will advise your member not to join Discovery. Which ties in with Judge's question as to what scheme...

MR. STEPHEN LAUFER It does indeed and the answer is not a simple answer.

DR BHENGU Is it possible because you have what I believe you have a wrong view when you call it an investment. Is it how you see short-term insurance? Are you unhappy in this case because the house has won, but you will be in a different situation if you have had quadruple heart bypasses and insurance of 2 million rand. Is that reason that you ... that you have paid more of what you have gotten out of the system but who knows going forward which is the reason that you do not want to...

MR. STEPHEN LAUFER I think that it is a valid criticism of my position but the point about it is that a large portion of my criticism is A) the lack of transparency in the way that Discovery does its business. I do not understand self-payment gaps, when they kick in and when they kick out and so on and so forth. Apparently I could make the effort to understand them but I do not have the time nor the inclination. I would rather have a simple system. That is point number 1. Point Number 2, the

treatment that I was subjected to by Discovery and its proxies last year is in my view not on. No matter what necessity there is to manage health processes. It is simply not on to do what they did.

Dr Bhengu Thanks Judge. I am all done.

JUDGE NGCOBO Yes, thank you. Yes...

10

PROF FONN I wanted to say that the costs presented at 6 differential costs about 50 000 for the intervention in Berlin and just over 100 000 for the intervention in Johannesburg and the I suppose the two steps could account for the difference. I have no idea what ...costs. But what I am curious about is how little did you know about the costs and if the experience in Berlin was any different the experience in Johannesburg in terms of costs and whether it is important for you to know those costs and how many of that plays out?

20

MR. STEPHEN LAUFER: I suppose part of the issue is that Discovery suggests to me as a member transparency by sending me an email after a particular event to say this is what we were charged, this is what we covered, this is what is your profit.

Whether it is a physiotherapist or whatever. And that is where I have taken these figures from in this particular instance. The experience is very similar. The experience was an acute issue...an angiogram, very similar lab in Berlin and in Johannesburg. The difference was in Johannesburg the overnight was in recovery. Recovery ward was 12 beds and in Berlin it was a private bed where I was alone. Which of those is better I suppose is debatable. There is more observation obviously in the 12 bed ward.

10

But other than that I didn't experience any difference. It may well be I am not aware what a stint costs. But that explains the difference. But if it explains the difference, there is still and interesting moment there because wage levels in Germany are a lot higher in South Africa. Which says there is a differentiate nevertheless in terms of if the costs are equal for everything besides the implant then this is an expensive place to pick up what I have had earlier evidence.

20

Prof Fonn It is one of my interests, are we or are we not expensive and does depend on how much the stint costs. I understand that.

MR. STEPHEN LAUFER Perhaps there was one small difference. The difference is as follows. In Johannesburg I was in a private hospital. In Berlin I was in a public owned hospital, in the private wards section.

PROF FONN And was, I understand one might be acutely ill they may not necessarily care or even have the capacity when something is going to cost. With insurance the idea is that the health insurance will cover that. But in any other
10 circumstance have you in your experience ever been told or want to know prior to an event what the cost implications are and potentially the cost implications that are to be picked up by the insurer and those to be picked up by yourself.

MR STEPHEN LAUFER My dentist does that on a regular basis if there is any treatment beyond the routine required. He provides a quote. He says this is what Discovery will cover, this is what you have to pay for yourself. And its one's choice
20 to accept that or not. Other than that I have not had any experience with that approach. Generally, I have discovered afterwards if Discovery has taken over the cost or I have discovered the checkup... So for example I have talked about the scan that I have had which is in connection with the, ... Where there was R182 that was not covered by Discovery in the end. I discovered that after.

PROF FONN I suppose what I am trying to ask, you spoke about transparency. I just want to be clear, clearly what you have explained so far is that you want to know how Discovery do things. Will that transparency also include, what is the cost to have x or why? And whose job is it to tell you?

MR STEPHEN LAUFER I suppose it is relevant to the individual. So then yes, I

10 would like transparency ahead of time. Post fact it is perhaps a little more than idle curiosity when watches what is going on...

JUDGE NGCOBO I want to suggest to you Mr. Laufer that it may well be perhaps a more fundamental reason why you do not ... It is not about investment. It is about the realization that you need access to health care services. Because if you do not need that, it would be an easy matter for you to walk out.

20

: It is a discussion that I have been having with my insurance broker interestingly. What I will do at some point is got to a lower Discovery offering which will give me exactly no more. I am going to take all of my chronic ... Mathematics is showing that I am going to come out ahead. I suppose it is not just about 15 years' membership

with Discovery. It is also about a lifetime of contributions. As an employee of various publishing companies of the State and so on I didn't have a choice but to make those payments and they went to the insurance company and they are lost in a sense or subsidized to other people in high care requirements and so on. All of that is correct.

JUDGE NGCOBO If for example a medical schemes where to come to you to say forget about what you paid and what you have paid. You could come to us with what you pay at the moment we will offer you the same benefits that you have been receiving. Would you move?

10

MR STEPHEN LAUFER I think it will be very nurture bound. Does this simplify my life. If it does?

MR STEPHEN LAUFER If it does then I would very much want to look at that option.

20

DR NKONKI: My first question is around your interaction with Discovery. You said you have been with them for about 15 years and during that time, have you tried to

approach your trustees and discussed with them the issues that you have raised with us?

MR STEPHEN LAUFER I haven't, to be honest my days as a crusader are behind me and I would rather prefer to get on with my own life rather than ...Discovery on the side. Which I haven't felt will have much hope anyway.

DR NKONKI And have you attended any of the annual general meetings?

10

MR STEPHEN LAUFER No.

DR NKONKI Then you talked about in your written submission that you did receive some assistance from your broker and can you describe how that process was and how you found the assistance from the broker with regards to getting your claims that were not authorized?

20

MR STEPHEN LAUFER Okay, so are we talking about the particular incident last year?

DR NKONKI Yes.

MR STEPHEN LAUFER My initial call was to him was to say how do I get Discovery to agree to agree with this. He gave me the number for SOS International. It was only really when I was back in Johannesburg and had a conversation with him and he said to me you know in that same week I had the same thing with another client of mine who was in Washington. And Discovery gave this person's medical Doctor a hugely hard time. Won't you write down this for me so that I can take it up.

10 Now he has not come back to me on how they responded to me. I suspect that I emailed him in a short time.

DR NKONKI Okay, and then I just want to go back to your statement when you asked about why you would consider leaving Discovery. We have about 26 open medical schemes. So you said you also talked to your broker but the possibility of going to a different medical schemes. His or her response to you was that Discovery

20 is the better compared to the other not so well performing Medical Schemes. But did he present you with any comparative options. So for instance if you are on comprehensive care this is what you would get from monitors from a different medical scheme these are the contributions. Did he present you with any of that evidence?

MR STEPHEN LAUFER No he didn't. And these conversations have been with a range of people. Essentially I will talk with some friends and how do you do it and how are you involved and so forth. I have a business partner who is a very good friend of mine for example who has his whole family insured with Discovery and he is very unhappy. At the cost of it and the way the necessary treatment then ...but essentially the feedback from whatever conversation has generally been that they are
10 the best of the bad guys.

DR NKONKI So what I am trying to understand is that on the basis of comparing what is really being offered and the prices and the training processes. For example, do you know whether Bonitas members complain as much as Discovery. I am just trying to understand what is the basis of your comparative.

20

MR STEPHEN LAUFER I do not really have the experience of that except that I was with other schemes and unfortunately I cannot tell you what they were anymore when I was employed for example by Times Media Group, when I was with the Mail and Guardian and when I worked for government and so on. Each of those was a

different one. And I think the fact that I was an employee and therefore not dealing with much of this directly and in those years not necessarily not having to deal with the kind of things one begins to deal with as one gets older, the experience was a different one. Simpler.

Dr Nkonki Thank you.

10 **DRS VAN GENT**... I can see your journals. It was hilarious sometimes. The exchange of your emails and I want to talk about this because your submission is part of your personal experience and it is very clear. And it is important I think. But you also talk to us as a professional. And then the last part of page 9 "Due to my professional vantage point it is a strategc communicator it is clear to me that there is significant gap between this government messaging and the ...it presents its clients". My question is, is this on purpose or is this just to your professional opinion of course.

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MR STEPHEN LAUFER My purpose by Discovery?

DRS VAN GENT Yes.

MR STEPHEN LAUFER It is very hard for me to know that but I think the observation will be as follows. There are many International reputation management companies that if they are called in by a big company they will roll out a massive good looking communications package. And I think it is always the task of the management of the company for whom the communications package is being put together and rolled out to ensure that the messaging and the reality are ...

10 : And then you said that is the task of Doctor ...and his staff.

MR STEPHEN LAUFER That is right. And perhaps to take it one step further the fact of the matter is it is not hard to go and procure all of that. The issue is then to insure that they do manage.

DRS CEES VAN GENT Right. That issue you know of being passionate about providing data and you said there is a discrepancy between the words and the reality.

20 And then you call that a ... error. I want to ask if that is and let us consider that Doctor Bloomberg knows there is a gap between the words and the reality. How can you call that, again from your professional point of view can you call that an error if we see Discovery being one of the most successful in terms of profit, growth,

membership and vitality programs in South Africa and even abroad. So how can that be a canal error?

MR STEPHEN LAUFER It is and interesting question because I think that many who are buying what they think they are buying do not know what they are buying. We live in an age of appearance. We buy appearance. I think when it gets to what is the substance of what we have paid for that the disillusion and the disappointment kicks in and certainly as I have said this is absolutely anecdotal. If I talk to people in my circle of friends it is when they hit reality that they become somewhat disgruntled and what looks exceptionally good between these two.

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DRS CEES VAN GENT I understand, what I am trying to get at and this is the 1st time I am talking to a professional like you on this specific issue in the enquiry. Can this be a rational strategy and a profitable strategy from your professional view?

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MR STEPHEN LAUFER I wouldn't want to look into the minds of Doctor Bloomberg and others but the fact of the matter is that this is how this has conducted itself, yes. Branding is a massive issue and how you brand yourself and how you sell that brand is a factor determining what the profit levels are.

DRS CEES VAN GENT Could branding be more important than the practical reality? We have heard evidence regrettably also from Discovery regrettably because we should talk about other medical schemes. And we have evidence to say that as soon as the branding comes into place and as soon as the client on FB 2 hours later things change. My question is; is the branding more important than reality and can that be a probable strategy?

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MR STEPHEN LAUFER Look, it is entirely speculative on my part but if we look at the fact that Discovery Holdings is a listed Company in the Financial services sector then arguably branding is more important than the preventative medical care. Medical care is the by and by. It may be the origins but it is certainly focused.

DRS CEES VAN GENT Okay thank you very much.

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JUSTICE SANDILE NGCOBO... is there anything else you would like to draw to our attention?

MR STEPHEN LAUFER No, I am comfortable thank you very much Judge. I think the real point was it is a very subjective point of view simply put before the enquiry. One person's experiences in the hope that one or the other sentences might assist you in your findings.

JUSTICE SANDILE NGCOBO What troubles me is why is a person of caliber, standing is able to tolerate the kind of treatment that you have described in your
10 submission. Something suggests to me that it is more than an investment. It may well be it is there isn't unrequited and that how can I afford given the history of my ailment to be without cover. Cover is not just luxury, it is a necessity which perhaps your case demonstrates eloquently because you have all the opportunities to leave but nevertheless you have decided not to for reasons that you have described to us not to leave.

20 **MR STEPHEN LAUFER** I think there are a number of answers to that quite complex question. The first is in the early years of membership I did try to fight for what I felt I should. So for example I wanted to be able to get three months of chronic medication at the time. It would be less of an issue for me and it meant that I had what I needed if I had to travel. I jumped through many Discovery loops including

filling up the necessary form... At some point I threw in the towel and quite honestly I couldn't afford to. Because my time doing other things was more valuable. In terms of last years' experience, I did try as I have documented here to get my view through to those at Discovery asking to comment. The fact that I haven't had any responses to this is fascinating to me, alright. It speaks at the level of contempt which is quite extraordinary I think. In terms of your cardinal point that I am getting older; the likelihood that I am going to get medical event of one kind or another is there;

10 absolutely. But that is more than the amount of more than the future cover. It is about the feeling that I am going to require this; Discovery has already ha a pound and a half of flesh and therefore it is only stick with them should this happen.

JUSTICE SANDILE NGCOBO I am raising this question with you because you know you are not the first one who has had covers coming here telling us stories of frustration but also their fear of leaving or being left without a cover.

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MR STEPHEN LAUFER And as I have said to you, one of the puzzles that my broker has made is that I downgrade my Discovery membership to what will take care of catastrophic ...

JUSTICE SANDILE NGCOBO And your broker makes that suggestion precisely because your broker realizes that you need access to ...

MR STEPHEN LAUFER On the one hand and on the other hand he recognizes the frustration and the shortcomings at a higher level.

JUSTICE SANDILE NGCOBO No, I understand. Is there anything else that you would like to share with us?

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MR STEPHEN LAUFER No, thank you I am comfortable.

JUSTICE SANDILE NGCOBO Thank you so much Mr. Laufer for coming to us and sharing your compassionate story with us. Thank you so much, thank you. Okay, the lunch adjournment at this stage and we will come back at 14:00 if Professor... is available. Understood. I understand Professor ... will be at 14:30. So shall we come back at 14:30 then. Thank you.

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[END OF SESSION ONE]

[START OF SESSION TWO]

JUSTICE SANDILE NGCOBO Good afternoon and thank you for coming to make a presentation here, I understand that you have some slides that you are going to present.

PROF ANDREW SARKIN First of all, I would like to just thank the review panel for allowing me this opportunity to present. Just to introduce myself, I am currently the Head of Cardiology at Steve Biko Hospital, which covers Northern Gauteng, as well as the whole of Mpumalanga's cardiac services and I am also on a joint appointment where I am Academic Head of Cardiology at the University of Pretoria. I am also a full time practice committee head for South Africa of the SA Heart Association. The views that I am giving today, although I have discussed this with the University and Gauteng Province and the Department of Health are my own personal views, I just want to… Those are views that I have had over being in Gauteng Health for many years. I have also worked I was fulltime for twenty years in Johannesburg running the Cardiac Intensive Care for a long period of time. Then I was in fact in the private sector as a private cardiologist for about three and a half years and then returned to the University of Pretoria as Head of Cardiology. So in

fact I have worked between both sectors and I am going to try and give a little bit of insight into what I have seen over these years in the South African health context. Just a little bit of an introduction and I would just like to introduce as well my colleagues, Dr Nairn, who comes from our department and has joined me just for a little bit of support.

JUSTICE SANDILE NGCOBO Yes, thank you.

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PROF ANDREW SARKIN So I have titled, this is just the main PowerPoint and I do have some other slides. I have titled my feelings as "Bridging the Divide – help for all" and I am going to use cardiology which is the field that I am in, but we will run it past as a microcosm in fact of health. My background was also in kidney diseases where I was a kidney specialist before I changed to cardiology so a lot of this will be pertinent to an overview of health rather than pure cardiac services. And I apologise if a lot of the information you have already had probably better than I can

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give in terms of the health in our country, but I will go through what I think is relevant.

So I think that after doing a lot of soul searching on this topic over the last fifteen or so years which is why I felt I would like to just chat, I think that one has to acknowledge where we come from as a health community in our country and I think that in order to go forward in a holistic way for health for all I think it is important that we acknowledge what we have achieved in our country health wise. And I think that this is very important in order to realise our shortcomings particularly when it relates to private health, the public interaction and that sort of thing.

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So we come from an incredibly strong base of health. We have a history of innovative world class health. In my field I have just come out of a meeting with Groote Schuur at Steve Biko which would be the first transplant meeting as a unified – I have just walked out of there and so we have a fantastic heritage of cardiac and normal health and in fact we have been pioneers of cardiac transplantation in our country. We innovated CAT-scan and more recently in fact, the HIV rollout has been a fantastic programme which has been developed and I think that although a lot

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of things have overshadowed our country, I was in an era where in fact the HIV patients were not given therapy and what we have achieved and are able to achieve is testament to what our health services can realise in South Africa and I think that this is important.

JUSTICE SANDILE NGCOBO Professor, if you could just explain these hospitals that are being referred to. You are the Head of Department of Cardiology at the University of Pretoria.

PROF ANDREW SARKIN Exactly.

JUSTICE SANDILE NGCOBO Okay, then this Steve Biko Academic

10 Hospital?

PROF ANDREW SARKIN So as an academic, I am both academic and clinical Head of Cardiology. So I have got a joint appointment where I, at the University of Pretoria head the cardiac department which is training and teaching, so I train both from undergraduate medical students to post graduate, the registrars that will become physicians and the postgraduate, in other words to become certified as practicing

20 cardiologists in our country. That is my University role. I have got an equal joint role with Gauteng Health and as Head of Cardiology at the Steve Biko Academic which was formerly Pretoria Academic, it is now Steve Biko Academic. I run the clinical services of cardiac patients which is a big service. We have an eight bed ICU at the hospital, a twenty bed pure cardiac ward and we also train the whole of

Mpumalanga. So effectively we supervise 8,5 million people for their cardiac services, for 8,5 million people. So I am in a joint University and clinical role.

JUSTICE SANDILE NGCOBO Yes, apart from Mpumalanga do you cover any other provinces?

PROF ANDREW SARKIN Northern Gauteng, north of Midrand falls under

10 Steve Biko.

JUSTICE SANDILE NGCOBO Right, then why is it called Academic Hospital?

PROF ANDREW SARKIN Okay, so the Steve Biko, there are ten training hospitals, teaching hospitals which are by the statutory regulations of Parliament each

20 hospital is joined to a University. So the current legislation dictates that all training of health, formalised training is at a teaching hospital which is a state hospital, a public hospital, and those are joined to a University. So the Steve Biko Academic would be a training hospital where the medical students would take the registrars

rotation and the chaps learn on patients while also doing a service. So their role is three-fold. One is to look after them, two is to teach and three is to produce research.

JUSTICE SANDILE NGCOBO To which University is it joined?

PROF ANDREW SARKIN The University of Pretoria.

10 ***CHAIRPERSON*** Yes, thank you.

PROF ANDREW SARKIN Thanks very much. So I was just discussing that we do come from an incredibly strong base of health in our country and I think that it very important having just returned from a training session in India, it made me realise that we have enormous resources and history and it is important to recognise in order to move on in a holistic way. What we have achieved as a country, not only in hi-tech medicine, because many people think that my field may be hi-tech but in fact even in logistics and from the HIV point of view we now have the highest number of patients on anti-retrovirals in the world. I think that although the National Department of Health, the Minister and all the players are currently playing their part in the health provision of our country I think that things could improve and I am

going to go through some personal insights and some examples of where I think that as a country things could improve to.

We have a very strong institutions of expertise. We have the training Universities attached to all the major teaching hospitals. From my particular area we have a very strong cardiac community, both in terms of personnel but also human expertise which is incredibly important and needs to be acknowledged. The National Department of

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Health genuinely wants things to improve and I think that one of the reasons why your review panel is so important is that there is a realisation that things do need to be accounted for and reflected on so that perhaps the country can move forward in a meaningful way. We have...

JUSTICE SANDILE NGCOBO How many of these training hospitals are there in the country? Are you able to give us that?

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PROF ANDREW SARKIN I think that, and I stand for correction by one, but I think it is nine training hospitals, and I stand for correction but there are nine training hospitals which train...

JUSTICE SANDILE NGCOBO And all of these are attached to a specific University?

PROF ANDREW SARKIN Absolutely. All the training hospitals are attached to a University.

JUSTICE SANDILE NGCOBO Yes, thank you.

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PROF ANDREW SARKIN So, we have currently in health strong hospitals, both in the public sector, all the training of our current graduates of doctors within the country are performed at public state hospitals, all of them. So every South African graduate had basically trained, if they did not have outside or postgraduate training at some limited institution, their training has happened throughout South Africa in training public sector hospitals and I think that is very important to acknowledge. We do have a strong base of private hospitals, human resources and fantastic current expertise and are involved in international collaborations for research and equipment and I am not only referring to cardiology, but in fact the other disciplines as well. So this is just a microcosm, I am speaking about cardiology but in fact that could be extended to the other specialities as well. And then finally I do believe that as a

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country despite the challenges that we have and perhaps various biases that we all come with there is goodwill around health and around our country, but I think that it will take some decisive action and what I would term a Marshall plan of health to move to the next stage in our country in terms of health provision and I do not apologise for saying that, but we will certainly need major adjustments if we are going to continue to provide health and to accelerate the output of health and doctors in our country over the next five, ten, fifteen and even twenty years.

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Now, this is a slide from the World Health Organisation which is really a, it explains world disease burden of health throughout the globe and you can see there from 1990 to 2020 how the epidemiology and the causes of illness throughout the globe has changed. If you look at 1990 the top three causes were in fact diseases of emerging countries or what we would term third world diseases or infectious diseases; respiratory infections, diarrhoea and peri-natal. What one can see though is in the next thirty years and we are now far off 2020, number one is coronary artery disease or ischemic heart disease and in fact that is what we are finding ourselves and that is why we need to acknowledge how our country is changing. So although I grew up in a system where we were very poor at looking after these diseases which are really public health issues, the country is moving into the realms of the rest of the world

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where coronary and heart disease is a major epidemic in our country. And what I am really going to show you is as a country how unless things change from our interaction of the public and private system, our planning of health, how we are going to be ill-equipped to deal with this and why your review of this is so important.

So, this is a slide, in fact it was given by the Minister of Health to me, where it shows what is termed the quadruple burden of health challenges in South Africa which
10 shows the major causes of health in our country and where the biggest need for it is. HIV, AIDS and tuberculosis has been a huge challenge in our country and I am certainly not going to spend long on this. We have done extremely well having nearly 20% of the global burden of HIV in our country and we have made major strides and hopefully we will do similarly in other quarters of health that we have. Violence and injury unfortunately still manifests in our country. New born child health and maternal health is a major worry in our country because we have a lot of
20 young women who do badly in pregnancy from health. But really what I wanted to show today is the non-communicable disease profile which in fact relates not only to the public sector, but to the private sector and we will delve into it a little bit deeper. So to a large extent HIV, AIDS and tuberculosis is in a way under control, violence and injury have to be dealt with on many fronts and these two groups are a reflection

of health provision in a country. Now one may say but why is maternal and new born important? Because that is probably the best measure of how health provision happens in society. If one wants to measure health provision in a country one needs to measure how you are treating young women in pregnancy and how your infant mortality is. But equally one needs to measure how you are dealing with non-communicable, for example strokes, high blood pressure and heart disease. And I am going to show you how our country is emerging from that front.

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Now this is a breakdown of health provision in our country and in fact I believe this slide underscores it, probably the facts that I am going to relate to you with the population currently estimated at 55 million we only have just over eight million South Africans that are in the private health sector, in other words insured people. Of those the average beneficiary according to the Council for Medical Schemes 2012, the average beneficiaries' age was 32 years of age so the average person, beneficiary of private health in our country is in fact 32 and I think that it is very important to

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realise is that the majority of insured people are very young in our country, the beneficiaries. The rest of that, the rest of the 55 million minus eight point something million relies on the public health system. So this slide shows medical practitioners per thousand of population, the majority of the patients are in the public sector where

80% are serviced or 84% and about 16% are in fact in our country only on health insurance and yet as you probably are well aware the majority of health provision in terms of doctors supply the insured rather than the majority of South Africans which is the non-insured and I am sure you have been shown this before.

Now on the background of that one may say, and that is really my message today or one of the messages, well that is fine. One's got two health systems that run
10 independently in a country. You have got those for the wealthier part of our community and those health resources which are for the majority which is the under-resourced or the un-insured and I am going to try and rely that I do not believe that system is neither equitable nor sustainable and most countries would not be able to carry this on and neither will we if those do not bridge the gap between this. Now we have an enormous discrepancy between income in our country, but health provision is creating a major problem by having two sectors where there is very little cross-talk
20 over those two sectors and I am going to go into that in a moment. So that this, and I am going to spin off with this little slide and the reason I am showing it to you is that this is an example perhaps of how health provision of the two sectors do need to interact, one cannot have the two health sectors are not separate, but overlapping health sectors and they have to by virtue that it is health, there has to be an

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acknowledgement that the two sectors are not independent, but both the private and the public health sector relate to each other and they are very tightly intertwined. And I am going to explain why this, taking this particular example among a whole lot that I could show. A Pretoria heart attack victim died after being turned away by at least six private hospitals the Beeld newspaper reported, I am just quoting this. The patient, Mr Jan [inaudible 20:07], 66, died in theatre at the Unitas Hospital in Centurion the seventh hospital approached to take him. His wife told the newspaper
10 he had a heart attack at his home in Mountain View at around 2am on Tuesday. She called NetCare, an ambulance service at their home within eight minutes and paramedics stabilised him. The paramedics then contacted Eugene Marais, Akasia, Moot, Bougainville Hospitals to be told that they were not accepting patients. Beeld reported that it was thought that this was because the intensive care units were full. The patient was also rejected by Montana and Wilgers hospital. Just after 4am the ambulance was accepted into Unitas and [inaudible 20:53] was rushed to theatre but
20 he died just after 7am. According to the newspaper NetCare and the Life Hospital group said they were investigating.

Now certainly this is just a paradigm, but I want to explain to the review in a very clear manner why I have picked this as a point. Now if you look at the field that we

are in, which is cardiac health, exactly like trauma we have a golden hour. So if one of us has a heart attack, God forbid in this panel, we would have an hour at which our heart function would be significantly deteriorated. By three hours one has for example about a mortality that now goes up significantly from a low mortality of 100% it drops down to three hours to 20%, so one in five people will be dead. So you've really got a golden hour.

10 ***JUSTICE SANDILE NGCOBO*** Sorry, you would have to explain that.

PROF ANDREW SARKIN Sure, so I am going to explain a little bit more. So what I am saying is that in a rationalised health service what would happen is that all of these hospitals would be co-ordinated, that is in a normal system, in a normalised country. At night if somebody has a heart attack they would divide a city into for example quadrants. So if one of us was living in X suburb, Arcadia let's just pick,

20 they would rush that patient then to the closest hospital which would be Steve Biko because it is the closest hospital, it is geographically close. On the other hand if you lived in the suburb of Montana, you would then go to the closest hospital in your area to get emergency therapy and all countries today which have a rationalised health service make provision that is not dependent only on the finances of the patient, on

whether they are able to take it but on what is expedient for the country and what is expedient for the patient. So what I am illustrating to you is a microcosm of health services where the distinction is not made on what is for the country and the individual the best, but at the moment unfortunately purely on what is in that person's pocket – to be blunt.

This is not a sustainable system so I am using this as a microcosm but what I am
10 saying is that we need to move to a unified health where all providers of health need to in some way look at a way that for example if a chap is having a heart attack there will be a provision for emergency service within that area, they will stabilise patients for that period and that they will build into it a holistic view which is for the best of the country, and for the citizens of South Africa. I am just using that as an example. I will give some more examples as well.

20 ***JUSTICE SANDILE NGCOBO*** I understand, but as you are talking I am trying to imagine how private hospitals view the provision in the Constitution which provides that every individual has the right to emergency healthcare.

PROF ANDREW SARKIN Absolutely, and this is a situation which I will give and in fact the Constitution dictates that health is a basic right, it is an accepted right to South Africans. There is some non-clarity about at what level is health a right and that we could discuss. There is also an acceptance, although very often it is not provided for that emergency health would be given at any site that a South African citizen irrespective of money would go there. But our systems are such that you will not be taken to the first hospital, port of call, nor accepted and I will give an example

10 where in some cases the patient will not be given that right to health, certainly not as an ongoing thing and in some instances even emergency health we are denying our citizens in some instances.

JUSTICE SANDILE NGCOBO Of those cases where a patient was denied medical services in an emergency?

20 ***PROF ANDREW SARKIN*** Absolutely.

JUSTICE SANDILE NGCOBO Thank you.

PROF ANDREW SARKIN So the reason I am illustrating this particular case is not about the individual but rather a reflection of the importance of provision of a holistic health to a nation as well as that one cannot divorce and individual hospital or an individual practitioner from the requirements and the needs of a country for planning which has to incorporate all health provision as well as a moral and dignity issue of providing health in a holistic way. And there are very few countries that have two completely clear model which ours has evolved into sadly, where the provision of health is completely related in a way to a large extent to the patients' income and the provision of health, rather than what is best for the country and what is best for the citizens of the country.

So, to go back to the microcosm of my field just to put it into some sort of realistic perspective that we could engage with we have about 175 active registered cardiologists in our country, tiny numbers. The public sector have about thirty five full time practicing cardiologists, there are some extra in terms of part times, but it is about thirty five of these practitioners are engaged in pure public service, training and looking after the 80% of the patients in our country. So we turn out small numbers in fact and this is something we need to look at as a country, but we are on average training about six cardiologists a year which is very small. But this is not only

cardiology, you could change this word to kidney specialists, you could change it to endocrinologists or diabetic specialists and one could change it to cardio-thoracic specialists. So this is really not particular to my field, I am just using it as an example. So of the 54 million as I mentioned eight point eight, or 16% of our population are insured, but the majority remain uninsured; in another way we have one state cardiologist per million population in South Africa.

10 So in our particular department there is only two qualified cardiologists serving eight million people effectively. In some provinces it is a little bit more but four provinces in South Africa have no cardiology cover whatsoever, there is no qualified cardiologist in four provinces in the country. So if you look at it, one cardiologist would serve on average in South Africa one million public sector patients. In the private sector it is one cardiologists to 50 000 citizens, in the private sector. So if you do a simple arithmatic we need to increase the number in the public sector by between conservatively 185 to 200 cardiologists to supply our countries needs.

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So the current paradigm that we have created where we have a completely separate two tiered model of public and private leads to an incredibly disproportionate serving of our communities, a non-cohesive and to a large extent unstructured plan to deal

with our population. Now if you look at for example the British Cardiac Society, they sit down to come back to the judges point, they look at how do you provide health for your country. So they will sit down every couple of years and say we do not have enough facilities in Leads, we are going to build a new cardiac centre and we need x cardiologists and x infrastructures. Our health has evolved in this country where people would get training and within a short period of time more recently, this is a new phenomenon in our country, go straight into private practice as doctors and
10 work in private institutions and not look at the whole overview of where does the country's health provisions need to be. So as I have set out we need to review holistically how do we set about on a course where we look as a country to providing health and how do we plan for it in the future. So this necessitates action as a community, cardiac wise, the public health system, the private health system, the state, Universities and the professional organisations that we all fall into need to take cognisance of this and plan in a unified way how do we do it. Certainly my message
20 would be to try and unify all of us so that we move forward in a cohesive way from the country's perspective.

This is a slide where we draw out the average number of cardiac practitioners that we are training and we falling extremely far short of the cardiologists. Just to put

perspective into this, we are training in the whole country six cardiologists on average a year – that is the whole country – and this is not only cardiology. [inaudible 32:39[DdK1]] you could put on here, it is less, endocrinology it is less, heart surgery it is much less than this. We have turned out on average over the last thirteen years six cardiologists per year. In the gray is surgical – we have turned out on average, here you can see three to four heart surgeons per year, country wide and the majority of these practitioners move straight into private healthcare, private
10 practice and serving the small limited proportion of our population. Now this is fraught in big problems because these people you may say well it is a right in a way to do as one wants – if you want to go and buy milk in a cafe, you have got the R10.00 that it costs or whatever the price is and you go and you pay for it and you then acquire the bottle of milk or anything else for that matter. Health is somewhat different as I perceive it, because in fact for a cardiologist to get trained it takes sixteen years; sixteen years that the state is paying for to a large extent at fairly large
20 salaries today and although obviously the person has themselves invested a lot of money, a lot of that investment is much beyond a salary. The Universities are subsidised as one well knows by the state. So very much like a kidney and a heart transplant has been stated now to be a national resource, one really needs to relook at how health is and I believe the time to look at health as a national resource because it

is, it is national resource, it is like the heritage of the country – it belongs to all of us. So it has taken sixteen years for example to train a cardiologist, that then obviously one has a right to an income and a right to life and all the rest that goes with it, that has to be balanced with the right to the states' provision of health and every other citizens' allowance of health because that training was in fact provided for by the Universities, by the state and then co-subsidized by all of us and I think that is where the realisation, I do not believe that health is just like any other commodity that you
10 could say I am happy to drive a Mini or a Mercedes Benz, you know health is a right at the moment and we need to relook at it as a country.

So, to come back to my particular field which we spoke about, we need about one cardiologist to one to two hundred thousand of the population. If you look at for example the United States, they have twenty six to forty two, per million. We have on average one per million – so just to give you some ideas. Britain has thirty five
20 per million, Europe ranges between seven and in Greece 210 cardiologists, but the average for the whole European Union is about fifty eight per million – we have one per million. So we really have a major shortage. It is not only cardiology, this is just a discrepancy in what we have in our country. The average age of cardiologists in the country is in their mid-fifties with the numbers declining. We have a massive

problem of sustainability in our country if we do not change things. Posts are massive problems, most departments have only two to four funded posts and as I said the majority of these people will go into private practice within a year or two and not really continue into the next generation and that is a massive problem. When I qualified at Johannesburg hospital there were fifteen cardiologists, most departments now have an average of one or two, some departments have three qualified. So the fact is that this needs to be looked at. Not only on the patients, but the sustainability

10 of health in the country because we as teachers give to the next generation. If they are not there, if the chaps in only a single solar private practice they are not giving on to the next generation and our country will soon decline and that is really the message that I wanted to give you here today.

So we need a structured plan as a country. We need to look at this in a holistic way of where we are going and we need to take all of this very seriously, not so much to

20 point fingers but really to move the country forward and we still have the resources in our country to move it forward. We only have, there are only seven registered electro-physiologists in the country able to, if you have got a rhythm problem to do an ablation in the whole country – that is all there is, there is two in the whole of the state sector left in this country and that is why I am [inaudible 37:56] on the need to

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deal with this as an urgent problem country wide. So I am going to go through the different sectors and give you a little bit of my personal insights if there is no question in the meantime, just to go through some of the problems and I will then go through a couple of individual cases which I just want to home in on.

So we have major challenges as a health system, we have ethical as I have mentioned, sustainabilities, issues of dignities and we are one of the only countries
10 which is not moving forward from a holistic point of view but rather an individuals' point of view or an individual hospital. Now we hear a lot about the two separate sectors and the argument is that if you mess up the one sector then it won't make any difference to do with the other sector improving and that is an argument which one hears many times repeated in articles in the late press, is you know bluntly put don't mess up something that is working and then you will have systems that are dysfunctional in both sectors. And I just want to get into that a little bit because that
20 is certainly not a model which one goes into, but if you look at these two sectors are deeply interrelated in the public and the private health systems. If a patient ends up with a majority of health diseases that we have, all of us are probably going to end up with cancer or diabetes or heart disease or cancer of some form, most of us, and most of us will end up having in our lives a chronic condition. That is what most of us will

have here in this audience and that is not something that is month to month, that is something that goes forward with our lives and needs therapy from a long continuum; having said that, the current system that we work in is often insured from a month to month basis. So if I go and pay my monthly medical aid, then which I am insured at the moment, then I fall off, there is no provision for a chronic plan in the current system so if one pitches into a private health facility and you need a specialised pacemaker, a specialised heart device they will tell you that you need to produce R250 000,00 which the majority of these patients today end up in the state and we put these devices in with taxpayers money. So these patients will continue in the private sector until they cannot afford it.

The state may have different guidelines for patients. So for example if one of these devices, and we have a massive problem, this is an example just to go through it – if somebody needs a heart failure device and they had heart failure and they have only got three months of life left, or six months, they will have an expensive device put in and when the battery runs out, they then get put across into the state sector and a big problem arises about whether the state then is able to finance this particular device. The same could be said for renal dialysis in our country – in other words there is no national guidelines – we do not as a country say these are our guidelines, both sectors

will follow them. If you end in renal failure and you go to a private facility or a public facility and the problem is that many of our population move from the one sector to the other. There is a lot of fluidity between these two sectors, they are not independent sectors so that if a patient gets a R250 000,00 pacemaker and their life expectancy is extremely short for example, the state has a big problem about whether then to pick up the resource of whether then we explain to them unfortunately we are unable to as a country offer you this device. I am just giving you an extreme
10 example.

Similarly as I have mentioned, dialysis, although it is a national resource, the two sectors work independently in that in the public sector the patient may be not eligible for dialysis because for example they are not a great transplantation candidate whereas the private sector is happy to carry on dialysis and when the money runs out then the state has to pick up the pieces very often. So ultimately many times the state
20 and public hospitals still end up involved in the patients which move in between these two sectors and I am going to explain to you why with many examples later. So, many times towards the end of a patients' life, the most expensive part of our lives as humans, medically speaking is the last three years of our lives because that is when it is estimated 80% of our medical expenses will be incurred – towards the last

three years of most of our lives and that is the realism. The sad part about it is our health insurance in our country works at the moment on a month to month model, with no provision of what is going to happen and I am in the same boat – I pay monthly – but what tends to happen, I am going to show it to you, is that as people get older in our society, they often lose their jobs or their earning potential goes down and they are thus then unable to carry on their medical finances and we see an enormous...

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There is not a ward round that I do not do at Steve Biko Hospital, there is seven to eight patients every time I do a ward round who were on medical cover, who have unfortunately been unable to because they have lost their jobs, because they are not well, they are ill, they then move across to the state sector for health care because they have contributed for many many years to reach their critical point where they are unable to work because they are not well, or they have lost their jobs, and suddenly now they end up in the state sector with no proper planning. The state

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health sector has not even been able to plan, not a day goes past that I do not get told there is a patient downstairs in the casualty who has got a flat pacemaker battery, they were not inserted by the state, they were put in under medical insurance. When the medical insurance now depletes or they are out of the yearly benefits then they

have to unfortunately comes October, rely on the state sector which we do – we do not turn them down, but a planned system where the patient would contribute in a health system for private health, where for example if you have contributed for ten or twenty years your benefits will not escalate by inflation or you would say listen if you have contributed for ten years or twenty years you carry on until you pass away would be a much more system for the country which is sustainable.

10 The current month to month system is not sustainable what is going on because there is no built in system where it does not escalate with inflation or when the person needs it most and loses their livelihood, they lose their medical insurance and are then suddenly transposed across to the state system to then pick up the pieces so to speak. So what I would propagate is that we do need to look at health insurance, whether it be private health insurance or national health insurance that there is a commitment for a true protection, like you do if you insure your house, that there is a long term plan made for these people, not month to month as we are seeing problems

20 in the public health sector.

Another problem that we encountering regularly is the costs of the health system at the moment is very high and we just see that this is becoming really very high. Some of it is in a way, in a health environment not often easy to deal with as a country because health provision is certainly a major challenge but having said that one of the things that I think we can go back to is that if we have only got 16% of our country in any form of health insurance we are really doing very badly as a country and I really do believe that if all players look beyond purely profit margin we could provide
10 much better health for our communities and I must say just some personal notes on this, I have just returned as I mentioned from India, and what really struck me is how the health system, both the state and they have a private system is so geared to making a plan to giving some sort of health provision. Even their private health system, there is this ability and willingness and want to try and factor in what the patients can afford and what resources are available. Or as one is increasingly seeing in our systems and this is just a broad statement, if you cannot buy into the system
20 when unfortunately there is no flexibility and no ability to negotiate some sort of a pricing perhaps.

So as I mentioned health insurance at the moment is a very short term month to month, but we deal with chronic illnesses, the majority of illnesses that we deal with

are chronic, that go over the persons' lives. So to be dealing with month to month issues is really to underscore as a country how we are going to take this whole matter forward – the costs of those that are insured need to be either fixed so it decreased with inflation or on a decreasing where if you have committed over a x number of years, there is it, but not that turfed out of the system once you are unable to contribute at the current going rate.

10 I do believe that National Health as a properly structured vehicle would take forward because equally we have patients at our hospitals and institutions –those that do have means and just rely on the state and unfortunately the state is not always good at checking up the resources of patients, we are not tied to the Receiver of Revenue for example and very often the patients that claim to be indigent are sadly not always as indigent as one might believe and the sad reality about that is that they are often denying those in need, the most in need, if they end up in the state system where people that need it the most are unable to. So I think that National Health will
20 hopefully and I think that this is a crucial thing – I think that as a country we need to look at how we are going to source health and how everybody is going to buy into that. Although medical insurance is meant to be non-profit by the way it is set up, we do see that many of these medical aids although they are non-profit organisations,

there is large amounts of wealth accumulated by the management companies, or the management vehicles that drive these medical aids. So I do believe that there is, as they say, meat on the bone to look at the whole medical aid industry and look at where the health can't be better provided, not only I mean as a family my wife and I with two little kids we are paying nearly R8 000,00 per month which is a massive portion of a state salary and the point about it is that I do believe that we can look at intermediate programmes and provide health better for our population at a more cost-
10 effective level and I really do believe that is possible and I saw it in India and I have seen it in other parts of the world working.

As doctors I think that unfortunately I think that we need to renew our continual community engagement and goodwill. I think that there has been a loss of ethos in our spirit of working by some of us, I think that many doctors qualify and go into private practice with no contribution. There are equally doctors who do come back
20 and service and train and teach, but many go into private practices within a year or two of qualifying do not contribute at all to the furtherance of the patients of the country nor to the training and teaching and I believe that a further form of post specialisation community service may need to be pursued in our country in order to make sure that there is ongoing giving back if you like, that people do not just qualify

and go straight into private health, but also contribute to the health of the community and to carrying on training. I think that, and I have been in private hospitals, I have worked in there and I will give you some examples but the cost has become exorbitant just to give it to you – it is absolutely exorbitant what is going on. Just to relay a story, many of you will and this is multi-factorial, but many of you may have heard on the radio and in fact Dr [Motsoaledi? 53:42] asked me to relay this story to you if I would for two minutes, but many of you may have heard on the radio on the weekend that there was a little kid who was admitted to a private hospital who is nine years of age in heart failure, who needs a heart transplant and the mother was sadly very upset on the radio over the weekend and they have had a bill which is just for a bridge transplantation, that is just to go... Not to have the heart transplant, but to have the device allowing this kid to survive, the device is R1,8 million to put it in and with the cost of further therapy and getting a transplant it will be estimated that another R1 million would be needed.

So before this kid even has a heart transplant the cost involved will be R2,8 million which is huge – the medical aid, although it is considered as what we would term a PMB condition prescribed minimum benefit, the medical aid in this particular case they are unable to afford that – the patient is currently covered, we know the costs are

massive but the medical aid has said, and the family took it directly to the Minister of Health who phoned me and said to me you know is there anything that should be more looked into and how do we deal with this, and please would I relay this just as an example to the Health Review Commission this morning, but the cost is enormous.

There is obviously big challenges with our Rand at the moment, but the fact is we
10 need to as a country at the moment look at how do we provide holistic care, not necessarily at that kind of money, but how do we sustain in all of this. But even for lesser procedures, if any of us would need a coronary angiogram which is not a very sophisticated procedure although you obviously need training, the hospital will make you pay a minimum of R30 000,00 and I am going to show you a case where a formal complaint has been laid where the hospital would not treat a patient in an emergency unless the patient came in the middle of the night with R120 000,00 in cash while he is having a heart attack.
20

So those are the barriers that we really do need to as a country break down because there are not many of us that could take out that kind of money in the middle of the night in your extremeness of health. So these costs are massive and I do not think

that these costs are necessary in any health system. So an angiogram with a stent would need probably R60 000,00 and I am going to show examples that ICD and a valve replacement in private sets you back R250 000,00 which is a lot of money in anybody's books. So we need to relook and I think that all the players including the medical sector, the private medical aids, the health groups, the hospital groups need to really look not as private health, as business but also beyond business as how do we provide for the needs of our community and really go back to the ethos of

10 provision.

We accept business but I think that there is more that one can do and unfortunately we have evolved in a way which could bring us back together again. So there needs to be greater engagement, of finding solutions, of treating patients often with emergencies and trying to find ways that we can find equitable health and affordable health for our people. [inaudible 57:22[DdK2]] devices, this is becoming a massive

20 problem in our country. Now one of the things that is happening is that devices which is, if you need a pacemaker or a stent in your heart or any other device that would be considered as devices, companies are bringing in devices now where they do not even register it or even give it to the state to use, they just bring it in for private use only and I do not apologise for saying that. There are valves that are now,

you don't have to open somebody's chest – if one of us needs a valve replacement, which is not an uncommon thing anymore, you can put it in through a little incision of a few millimetres and push it up into the heart and deploy it and today this is becoming mainstream. The companies bring it in, they don't even necessarily engage with the state sector, they quote at R230 000,00 for a single valve, the companies and I can mention them, but there is no ways that a quarter of a million Rand can be picked up, so they only bring these devices in for those that can afford it,
10 simple.

There is no, and I do not apologise for saying that, there is no compassionate use or saying that we will give it and we have to and unfortunately the legislation for this is lacking at the moment. In New Zealand for example if you want to use certain drugs they have to be available, but they are on a broader scale and I think we need to relook at that. As a country if these devices are not able to be used in training
20 hospitals, one questions whether they should really be in ones country and I do not apologise for saying that because it is not only about the few odd people that it is treating, it is about the sustainability of training, it is about the ethics in the country and it is about the dignity of all our people if you are not providing that and

companies that are only brining in devices that can be used in wealthy needs to have their ethics questioned and I really do not apologise for saying that.

So the state also needs to do more, sorry.

JUSTICE SANDILE NGCOBO The distinction between pharmacies and the device companies.

10 ***PROF ANDREW SARKIN*** Okay, very important question. So in fact the pharmaceuticals have been much more regulated in our country because there is the Medicine Control Council and Medicine Control Act which is very tightly regulated at the moment, the registration of a drug and pharmaceuticals is much more closely scrutinised than the device industry. So the device industry at the moment has to be registered with the Radiation Board if we use it for example, but very often the regulation behind it has not been as closely. My understanding is the Department of

20 Health has been in the process of trying to regulate this for some time and they are looking at it, but devices are less regulated than pharmaceuticals. Most countries have got a very tight regulatory authority for devices. We have a very loose thing and this is creating quite a lot of problems because for example if a new device comes into the country they should be under very close scrutiny, it should be in

teaching hospitals, it should be very carefully scrutinised and followed up, both in terms of safety issues, in terms of costing issues and in terms of if there is any untoward affects of some new device. We have a completely unregulated system, so people in a private practice could just put them in for example. There is very little, we do not have very strong accountabilities in our country and I say that not only for the private sector, but even in the public sector the accountability issues so strong today overseas, that if you want to have a bypass in the United States you can go to
10 the internet and say Professor Sarkin is going to operate tomorrow, what was his mortality last year, it is available, the United States publishes those, we don't have that, people can just do what they want in practice, they can put in a device, it is not properly legislated and there is no, and we do as a country need to take this forward. Both from a safety and costing and costing is becoming an issue and I believe that if these devices are not available at least in training hospitals, in some sort of a process, one needs to look at the whole way that as a country, we are utilising these devices.
20 The State also and certainly I know that the Commission is due to look into private healthcare. One does have to acknowledge our shortcomings and we certainly have major shortcomings in the State sector, there's no doubt about it. The sad reality as a country and one needs to be open and transparent, if the State sector to some extent, had managed to pursue health in a stronger way perhaps, or to overcome some of the

challenges that we face, perhaps the private sector would not have grown to the extent that it has grown and to in fact become this large mushroom.

When I qualified in the 80's, in fact the private health sector in South Africa, was not very, very how could I put it to you, was not only very strong, but it was not very expensive and they weren't attracting the majority of the doctors in some way, worked in the public health and you were like you are in Britain, if you weren't part of a training department, you were not really one of your community. In other words, the ethos and the training and the major intellectual discussions, were in the training departments, whereas very often today, it's seen as a normalised society, that people just go into solo practices with very little accountability.

10

The role that one hears, that yes but the private sector, run a very efficient model, is not necessarily so correct and I don't apologise for always saying that. There is a lot of expertise in the private sector, in the private health sector, but there also is very little accountability and a way, because one can open up shop and one doesn't need to print to anybody your outcomes or your expenses in terms of the medical costs, whereas for example, I'm accountable if I don't do well on patients, the hospital CEO or the National Department of Health call me in and say Andrew what's going on here.

20

So we do have accountability and in fact, so much so in my field, that although the efficiency in terms of patient turnaround maybe seen to be very efficient, one of the major medical aids for example, has realised that angiograms which are performed in the private sector, 80% of them or about there, don't go onto any destination therapy, questioning whether this is actually always necessary and I think one needs to be fairly open, that there is over-servicing in the private sector and almost certainly major under-servicing in the public sector. There is no doubt about it, we under-serve for example cardiac wise, because we don't have the health resources and equally, there is over-servicing, because many of these patients, so if you look at for example, coronary angiograms, one should be performing about 10% to 20% normal angiograms if one's getting it right.

Some of the medical aids have shown figures where 80% of the angiograms being performed in private sector, are not needing to be done, meaning they're not going on to some sort of destination therapy, so there is equally we under-service and there's no doubt about it, that there is over-servicing, not only from the point of view of money or patients, but for example, somebody who's got chest pain, doesn't always need to see a cardiologist. Tomorrow if anyone of us have chest pain, you could

phone a private cardiologist and say I've got chest pain and they will fit you in, whereas in the State, it will take months before you necessarily get referred, so we are not building a country which is on the need, but also on the health provision from a purely financial model.

So the State is to acknowledge it needs to look more closely at this and we need to acknowledge the shortfalls in our systems and the lack of expertise that we have and
10 the improvement certainly that in certain sectors, could be. There are major managerial issues in terms of certain sectors while the National Department of Health often tries their very best, there are still major limitations to our health and with the new numbers of people that we've got in our systems, until things change, this won't be changed meaningfully. In fact, to a large extent, the human resources are in fact being curtailed.

20 We need to look at ways that the State and the private sector can work better together and I think that there are some earlier initiations of this and we for example, there has been some funding in very limited ways from hospital groups and medical aids to help in training, but by and large, this is very ad-hoc rather than a sustained nature, so although there is some, the majority of the costs of training in our country, is borne

by the State and the majority of the healthcare workers, certainly the doctors will end in the private sector and although there is a [inaudible], it's very ad-hoc from the private sector and I think that there traditionally has been a degree of mistrust between these 2 sectors in good communication and I think that things could improve there if things were, but for the good of all the country and I think that this is a necessary way that the country needs to move forward.

10 I think that the private sector, because they're using a significant amount of our health resources, needs to accept this and there needs to be a model of funding of training and a health provision not only to those that are on the higher echelons of income, but also looking at how they can provide health to a more meaningful part of our communities.

I think that we need a health line, I think we need to look at whether we can't have a health line, not 702 necessarily, but where people can openly phone and engage. The 20 current investigations into health take forever long. If a patient phones up and complains, it goes through a whole long laborious system and even if there's corrective actions at the moment, there's very little punitive costs that are placed on the role players, so there is just generally an apology that there was a mistake in

analysing the claim or whatever it is, but there is no punitive costs in the system, or to say listen you know as a health provider, or as a health group, it wasn't fair and that there should be some punitive costs or a fund, so that people do fall into line with and it's too easy to turn down claims in emergencies and every week we end up with a patient in the hospital who has got health, who is on a medical aid and then they refuse and when you phone them, then there's a problem, yes but he's on an exclusion period or we didn't understand that it was a PMB and in the end, once

10 they're in the system, the State obviously picks up the pieces. So I really think that a health hotline with an independent investigative team would look better at it.

Finally, before we get onto perhaps some examples, I really think the time has come that we need a marshal plan of health in our country, where we can look at health going forward from the country's point of view and the citizens, rather than from a costing and an individual point of view. Obviously cost is important, so those are

20 just, I know it's a very broad thing and I will furnish you with some complaints that, for example and I can read some of them, because you asked for some examples which I'm happy to read out.

JUSTICE SANDILE NGCOBO There is a couple of these that you provided to us.

PROFESOR ANDREW SARKIN So in fact this only came about recently. I collected some over the last few weeks. In fact the Minister of Health asked me
10 when we were recently engaging, if I would collect some of these cases and perhaps show them to the review panel Judge and then look at some of these.

The one here you will see is this particular patient who wrote, I in fact just asked him to write here, basically saying that he was denied emergency therapy. I also, I don't think it's necessary to read through the whole thing, unless you would like me to, or to go into it in great detail.

20

I also provided the panel with lists of some of the costs, I think it's on, one of those, I think it's called of just over a short period, what we did, is looked at the patients who, I'll just tell you which one it is, hang on, Table Pricing Investigation, the last one.

JUSTICE SANDILE NGCOBO Perhaps before you get there, in relation to the recent cases where the care was compromised due to funding, in addition to what you have, you've given us 6 as I understand, do you have additional ones that are not here?

PROF ANDREW SARKIN Yes open that one sorry, I'm not sure, go down, so there were 6 and then there's all of these which is about twenty, you've got those.

10

JUSTICE SANDILE NGCOBO Okay yes.

PROF ANDREW SARKIN So these are patients that have been on cover and have then moved across if you would like. These are just patients over the last few weeks where I made notes and I can provide you, I think you might have these, because in fact the Minister of Health asked me for copies as well, he might have submitted them, each one individually I'm not sure if he did, but these are in fact, individual cases that I drew up and what the rough cost was and why they had moved from the one sector into the other sector.

20

DR VAN GENT [inaudible] 7 to 8 people on average are dropout from medical schemes?

PROF ANDREW SARKIN Maybe a bit lower than that, I meant of the inpatients, so we have a twenty bedded ward and we normally have about twenty other cardiacs in the other wards, but at any one time, there will be at least 7 or 8 that were funded and due to an acute problem, they end up in the public sector, at any one time.

10 In fact, I made 2 little video clips here of patients that are currently in and I asked them last week as I was given today's date on Friday I think it was, if they would make a little personal gesture and just show you and maybe we can just open, these are patients that have ended up, there just in a ward last week and I went to them and I said would they mind being in a little interview, they speak not me and just explain why they were in there and what was their current problem of moving.

20 I really just wanted to relay that these are not 2 separate systems, they are very fluid systems because all of these people, we are all going to end up in problems, the whole lot of us at some stage.

JUSTICE SANDILE NGCOBO Just for purposes of the record, I think we should record the documents that you have furnished to us. The first document to which you have referred, is a document which is headed "some recent cases where care of patients were compromise due to funding issues", that is the first document.

PROF ANDREW SARKIN Right.

10 ***JUSTICE SANDILE NGCOBO*** Now can we mark that document perhaps as AS1.

PROF ANDREW SARKIN Is that this document Judge?

JUSTICE SANDILE NGCOBO No, the very first one which says "some recent cases where care of patients compromised" where you have a list of [interjects]

20

PROF ANDREW SARKIN Maybe you can just show it to me, oh that one okay, sure absolutely, that one you will call AS1.

JUSTICE SANDILE NGCOBO Shall we make that AS1?

PROF ANDREW SARKIN Right.

JUSTICE SANDILE NGCOBO And then the second document is one which is headed "patients referred to the public sector due to failure by private medical system", I think this is the document which has got about A to N list of patients.

10

PROF ANDREW SARKIN Just show it.

JUSTICE SANDILE NGCOBO It has got tables.

PROF ANDREW SARKIN Okay that was table pricing yes sorry, I think that's this document, we will call that one [interjects]

20

JUSTICE SANDILE NGCOBO Shall we call that AS2?

PROF ANDREW SARKIN Just open it please? That one?

JUSTICE SANDILE NGCOBO Yes, so we will call that AS2?

PROF ANDREW SARKIN Sure.

JUSTICE SANDILE NGCOBO Yes and then the next document is that which, just for the record, I'll simply call NJJB, which is an individual who had this misfortune whilst he was at a guesthouse.

PROF ANDREW SARKIN Sure what are you going to call that one?

JUSTICE SANDILE NGCOBO Shall we call that, what is it, I've lost the number.

PROF ANDREW SARKIN It's the third document.

JUSTICE SANDILE NGCOBO Is it AS3 yes.

PROF ANDREW SARKIN AS3.

JUSTICE SANDILE NGCOBO Okay very well, now what other documents are there?

PROF ANDREW SARKIN Okay then I've got 2 little video clips which we could call and perhaps show them now, go to the second one maybe, 15 yes, these are just 2, we could call that one AS4, these are just patients that were in last week,

10 which I asked just to relay.

JUSTICE SANDILE NGCOBO And you spoke to them?

PROF ANDREW SARKIN I spoke to them and got permission Judge.

JUSTICE SANDILE NGCOBO Yes.

20 ***PROF ANDREW SARKIN*** To use their thing and they volunteered that they would like to make a little plea.

[Video 1:18:55 – 1:20:27]

Sitting there waiting, as I said on the ward round, literally last week, so I just made it. Perhaps the other one, this chap is on a medical aid. He has a R230 000 device and the medical aid currently he is on the top plan, the executive plan of one of the big medical aids and they've refused to cover him and the reason is that although he had a pre-existing, he paid 10 years, this other patient, he then defaulted if I understood for 2 months and re-joined, or changed jobs I think, you will hear it and then what happened, is that they excluded him, so now that this thing needs to be replaced,
10 although it was pre-existing, the idea of exclusion was that you didn't join a medical aid and then know that there's something catastrophically wrong with you and join it the next day so that you did.

It wasn't that somebody was on for a long period, changed jobs and now it would be used that default clause as a way to get out of looking after the patient. This is a typical thing, he's lying there at the moment this chap. You can show the next one
20 thanks very much. [Video 1:21:41 – 1:23:11] So these were just 2 sort of very short [interjects]

JUSTICE SANDILE NGCOBO The last video, that individual stopped contributing because the company filed for bankruptcy, is that right?

PROF ANDREW SARKIN Ja.

JUSTICE SANDILE NGCOBO Right now did he then re-join the medical aid?

PROF ANDREW SARKIN He re-joined the same medical aid.

10 ***JUSTICE SANDILE NGCOBO*** The same medical aid?

PROF ANDREW SARKIN Same medical aid.

JUSTICE SANDILE NGCOBO And then of course when he re-joined, he was excluded?

20 ***PROF ANDREW SARKIN*** Excluded, he was known to already have the cardiac issue and then he was excluded.

JUSTICE SANDILE NGCOBO Because they say he should have disclosed that fact when he re-joined?

PROF ANDREW SARKIN No he did disclose, but it was like they were negotiating a brand new contract from scratch again.

JUSTICE SANDILE NGCOBO Okay I understand.

DR BHENGUJust to be sure, he was accepted onto the medical aid of course with
10 the exclusion for the cardiac condition?

PROF ANDREW SARKIN Yes and one of the other things, it is not just about 2, we have this every week you know every week, I don't even, it is too difficult, because my job is not to fight on patients insured, it's easier just to provide their health and the State picks it up, but one of the other massive problems that we are having at the moment cardiologically, is that patients are excluded for hypertension,
20 or high blood pressure and then when it comes to a condition which is very common, many of us, about 30% of those of us who are over forty, will have high blood pressure, but what then is happening now more and more, is that when high blood pressure comes and the person gets a heart problem, the relationship is but hypertension is the underlying reason, so basically and many of us don't even know

this, if one is excluded with hypertension or high blood pressure for the year, that excludes in many medical aids, that excludes heart failure, heart disease, a heart attack, a stroke, kidney failure, because all of them are deemed to be due to the high blood pressure.

DR VAN GENT They don't have to prove the actual cause?

10

PROF ANDREW SARKIN Absolutely, so they just exclude it and they'll say and we have this every week because I say to them you know but why do you exclude it, but no the hypertension was excluded and then when they say the reason is because hypertension causes, the hypertension causes everything virtually, but most of us end up in problems except for cancer, hypertension will be involved.

20

So there are a lot of things. Sometimes we do, you know although obviously my job description is not to fight a medical aid, because once it's in the hospital, we give it cover and then when you do take it on, then they say well there was a misunderstanding and all this, but there is an enormous thing and most patients don't always know their rights, because you need to be very strong-willed persistent and

you know, competitive to sometimes take these issues forward, but it is really becoming a major issue in terms of State's help.

Not only those that are truly on, but those that were on, but fall off and they fall off because they get ill and they get a bit older and the incomes drop, so you know that's why most of us, it's not, you don't need medical aid when you're younger, you mostly need it when you're older and not well.

10

JUSTICE SANDILE NGCOBO Do you still have something to say in your presentation?

PROF ANDREW SARKIN I think from the documents, that we've covered most of it Judge.

20

JUSTICE SANDILE NGCOBO Okay very well, those of my colleagues who have questions will put questions to you.

PROF ANDREW SARKIN Sure.

DR BHENGU Thank you Prof for your presentation. I think that there are quite a few areas of interest that I just want to follow up on, but I must just start by saying that one statement that caught me, is the one where you said we are one of the only countries in the world who have practitioners who can practice completely outside of the State system, that I found interesting.

I just have one initial quick question, I am pleased that you've worked in private sector as well, so you do have experience in terms of what happens on the ground. The question I want to ask, I've asked before, but as a practitioner, there are obviously huge structural sort of both the private sector and public sector, there are differences just from a structural perspective and I just want you to give us a view of your assessment and the safety or lack of from a patient perspective, the fact that obviously if you are in private practice, you really are in a solo practice as opposed to being part of a huge team in public service.

I understand the systems are different, but the interest for me, is to what extent that affects the quality of medicine practised and what can be done to minimise any shortcomings if you think there are.

PROF ANDREW SARKIN First of all, I think that one needs to acknowledge that our training in this country, has traditionally and I think certainly at postgraduate training, has been excellent. I think that there are issues in any system where you're going to get some people falling by the wayside so to speak or problematic.
Perhaps at general practitioner level, in terms of it maybe more than in my area, because remember that in our area, the chaps have been trained for a long period of time. Having said that, there's no doubt that unless you've got accountability in a

10 health system with an impartial system of accountability, there's no doubt that procedures will happen unnecessarily, that patients safety by the very virtue, will be compromised and to give you a little bit of just an analogy, if you look at the best, the top unit in Britain during heart transplantation, the [inaudible] of heart transplant units in England, Sir Magdi Yacoub, was closed down by the British authority, because their mortality went over 3%.

20 So we are all capable of wayward trends and that's why health provision in a country needs to be monitored, not only because you might get one person who's completely wayward, but because you need to know what is going on and although in the State sector there are major problems as well, but in a solo practice, you can virtually do what you want. Nobody analyses your mortality, your outcomes, how many normals

are you doing. As I mentioned in my field, you should be doing 10% to 20% normals if you've an 80% of people that are not well.

But if you've got statistics that's the other way around, one has to question why is it that your country is doing in certain sectors, the opposite, 80% patients who don't need destination therapy, so I think that to answer your question, one does need always reviews, although the integrity may be there, until one questions and similarly

10 and it is not only the doctors, I'm talking about the medical aids, the insurers, the outcomes, the stats, what kind of population are you treating etcetera and one needs to introduce that and we are lacking in that.

DR BHENGUSo the specialists in private practice being independent, basically has [interjects]

20 ***PROF ANDREW SARKIN*** Very little regulation absolutely, unless a formal complaint comes through.

DR BHENGUOkay no thank you. Doc you said you were in practice for 3 years, private sector for 3 years. Which years were these?

PROF ANDREW SARKIN It was October 2006 until about the beginning I think it was 2010 when I started at university.

DR BHENGUAnd you had a fulltime practice, you said that as well in describing yourself, but [interjects]

PROF ANDREW SARKIN I was in private practice as a private cardiologist for

10 3 years.

DR BHENGUAll right now I just want to move into the area of coding. I'm assuming that you will be familiar with it of course, in your practice you need it, but I don't know the technical aspects of it, I don't know if it's also an area that you are comfortable with.

20 ***PROF ANDREW SARKIN*** In broad principles, I know.

DR BHENGUYes in broad principles, now when a group of practitioners, wants to introduce a series of codes into the system, what process is followed?

PROF ANDREW SARKIN So I'm going to speak about my own area, because that I know about. If the group of doctors feels currently they are not being fairly remunerated for a procedure or a new procedure, or the procedure is very long or it's not coded in a way that they would find acceptable, they mostly themselves, would have a meeting as a group of doctors and thrash out where they believe that there is a problem of coding and normally then there is for example in our area cardiology, we have an umbrella organisation called South African Heart which we generally belong
10 to, which is our organisation.

Within that organisation, there is a group called the Private Practice Committee and the Private Practice Committee would then discuss what they deemed to be a problem of remuneration, I'm talking about doctors now and then they would look at what they believed was fair and what international other countries perhaps in private, look at and what they believe was fair remuneration and then usually meet with some of
20 the big players in terms of medical aids and usually once they have negotiated, the smaller medical aids will usually accept that as well.

Sometimes my understanding is I haven't been involved in these negotiations per say, but I do hear and I'm party to quite a lot of hearing of what goes on in our

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industry, so then there would be some sort of a process and often it would reach a settlement of what would be reasonable to remunerate the doctor. Sometimes it would not be an easy negotiation and then the doctors would then, the code would be entrenched and what would be acceptable financially and what kind of patient they would remunerate.

DR BHENGUBut to what extent do you say doctors are successful in getting the codes they want? Is their significant push-back or do they usually get what they want and what happens if they don't get the codes they want?

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PROF ANDREW SARKIN I haven't been formally party to those negotiations individually, so you know, by and large having been in private practice and I'm now giving my personal impression, the majority of procedures and what one does, is by and large, coded. The problems come sometimes when a new procedure arises or it's a very, very long procedure, but by and large in our area, I can't speak about others, by and large, I think it would be fair to say that the majority of cardiologists in this country, don't have major issues where and I might be speaking unfair, because I'm not representing them and I'm not here to speak about coding, but just having been socially friendly and hearing a lot, I don't think there is a lot of, there might be an

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individual issue, but by and large, the majority of procedures one does as a cardiologist, is reimbursed.

DR BHENGU Okay now it's fine, I don't want to go too technical, but I think at a principal level, given that on the one side, there are very clear interests here at play in terms of determining codes. On the one side, you've got the clinicians who themselves are broken up, whether it's diagnostic consulting or surgical discipline, who obviously have their own different interests and on the other side, it's the funders.

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Would it be reasonable in your opinion, for the funders to run with this process in deciding on what codes need to be introduced, how they should be managed? Do you think that's a way forward?

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PROF ANDREW SARKIN Look when it comes to funding, I think that you know each side of the coin, would have their own how can I put it, would have their own impetus. If you are charging them, you want more remuneration. If you are funding and you said that I'm trying to split the pie, then you will try and less fund. So those are obviously you know pools on both sides you can say.

DR BHENGU The conflict part of issues.

PROF ANDREW SARKIN The problem as I see it as well, is that very little input into how does the non-funded get into the funded pool in a fair way, that's where there often is a discrepancy, so most of the patients are funded either at 100% of medical aid fees and if they're on a high plan, they are often funded some of them,
10 to 3 times the medical aid, depending on what plan.

Most of the doctors, if the patient is funded, there are not many patients who a doctor would turn down, there are occasions, but the majority of patients that are funded, would be able to access private health by and large.

DR BHENGUOkay I'm just trying to stay within the codings, as I said, I'm not
20 going to get technical, but I like that you've been in private sector, so it's not completely foreign. Now obviously if one is looking at these conflict of interest issues, it stands to reason that part of the panel in terms of recommendation would need to look at, are structures that would be not involved directly, I mean third party. Now we can argue whether which party would be ideal, but I want to ask specifically

about your views if this is necessarily we should consider that this be an academic institution driven process.

Why I'm saying that, I'm looking for a third party that's not involved, a third party that have clinicians, surgical disciplines, consulting and they have academic departments, they are economists, financial experts, I'm just testing whether since you also wear an academic hat, I know it's probably unfair you've never thought of

10 it, but this is the process we start. Is in your view, the academia area, the area where we should look as a potential solution for looking at coding on a long term institutionalised basis?

PROF ANDREW SARKIN Sorry I just want to get it clear, looking for coding, or looking for health provision?

20 ***DR BHENGU***No specifically coding, this is a big issue, as I said, I understand if you don't want to go, but we need to start finding out if this is one viable issue and I'm saying I thought I'd ask you as you've been in practice, you teach, you part of a university.

PROF ANDREW SARKIN Sure.

JUSTICE SANDILE NGCOBO Professor Sarkin let me say this to you, if it is a matter that you have not considered, please tell us, because you've come here to testify on the basis of a presentation that you've made and I would assume that you would be much more comfortable answering questions based on the presentation that you've given us and the sort of expertise that you have, so please don't feel to
10 commit yourself to a position.

PROF ANDREW SARKIN No absolutely, I'm thinking on the spot about it, because I didn't come prepared. I envisage that if the academic departments were involved on a nitty gritty basis with coding issues and per procedure, it could be an enormously problematic environment.

20 Having said that, I would like to just mention that without getting into individual incomes of doctors, I think it is important to realise that there's been a lot of you know, there seems to be hostility that the doctors are charging a lot and I certainly don't want to make a valued statement on that.

Having said that, I think that it's important to realise that of the total health bill buildings, you know costings, it's only about probably 15% of hospitalisations in my area, are [inaudible], now what is the cost of a cardiologist worth in time and per procedure, I certainly don't think academic departments are necessarily the right, because I think it would get into a huge amount of unhappiness from our colleagues and I don't see how role. If it was being involved in a broad process it may be, in a micro chasm of it dealing with individual problems, I don't see our role perhaps as
10 that.

DR BHENGUNo it's fine, I won't press further on that, but is the issue you've got a few cardiologists in the country and you showed thirty five only.

PROF ANDREW SARKIN Sure in the public sector full time Ja.

20 ***DR BHENGU***Are ARUAPS a problem in your area?

PROF ANDREW SARKIN In our particular, there are instances where ARUAPS are generally a problem, not so much in the hospitals that I work in, because we are particularly tightly regulated. I'm aware without getting into specifics, which I don't

think it would be a good thing. There are problems with ARUAPS, but by and large, it's not really where the major problem I think lies. The problem is the volume of doctors that the country have with public sector. There are instances where individuals are wayward, but by and large, I think that the systems can deal with that person. Certainly in our hospital, it is dealt with quite sternly.

DR BHENGUOkay so you saying you haven't seen enough to worry if they should
10 be pursued or continued as a means to keep doctors in public service?

PROF ANDREW SARKIN Look I think that one of the problems at the moment, is that the discrepancy in my area for example, the discrepancy in income is big. I mean I'm just being honest with you. So that a private chap would be 5 times the income that I make, so it is really quite substantially different.

20 One has to, this issue of ARUAPS, is a very difficult issue, because it needs to be done within the confines of the people doing the work properly. On the other hand, I was dead against ARUAPS fifteen years ago, I was very against it. Having said that now, I have done quite a lot of introspection more recently and I think that if you get a younger person and you want to keep them in a fulltime academic department and

if you don't allow within their regulation, a little bit of ARUAPS, you're probably and I'm talking as a head of department now, I'm on the other end, because now I've got to keep these people in my staff, if you don't allow them perhaps a little bit of ARUAPS, you are going to have to find a very special academic and perhaps somebody who is not very practical and they look after patients daily, to keep these people long term.

I'm not talking about my level I'm talking about the younger chaps. You are going to battle, so the majority of chaps do do some ARUAPS to be frank and it needs to be properly monitored and adhered to, but the country has evolved that ironically, the stronger departments have allowed the younger people to do some limited private practice, but certainly that should not be at the expense of not doing their jobs and certainly I wouldn't allow it and I know our hospital wouldn't, but then there have been instances, I can tell you. I don't know if I'm answering you.

DR BHENGU No you are thank you very much, that's all Judge.

PROF FONN Thanks Professor Sarkin, I wanted to understand you presented to us some data on the costs of care in the private sector, you said the costs are going up and you say they're exorbitant, are they rational in the sense, is it really

costing more, or is someone making a profit? It could be the hospital, it could be the doctor, it could be the pathologist, I don't care who it is, but is that what it costs?

PROF ANDREW SARKIN I don't believe so, you know I'm sure you are going to hear over your review a lot to say. Now you're asking me a loaded question because in a free market context, if you subscribe to free market economies, you charge what you can get, because that's what the free market is based on, so if you've
10 got limited resources which you've got in the country, meaning for examples doctors, then you know the chap can and even if they were to double their fees, they will still have patients, because there is not a lot of humans, so if you subscribe to that, then that's what the value of your time is in a free market system.

I have tried to portray to the committee today that I don't believe that health should be completely free market, because if it's a completely free market, you would have
20 no health in our country, because of the history, the historical history, the numbers, expertise and all that, so I don't believe that health is completely, should be driven by free market factors.

You've obviously got to have a fair dispensation for the person, what is the fairness and where do you draw that, obviously the line. Could we do better? I have no doubt, I have no doubt about it and you know I can speak with certainty that there's a lot, you know I always watch that programme [inaudible] Archeologists and they use the term "is there meat on the bone" and I believe there's meat on the bone, plenty and there's meat on the bone from to some extent, the doctors, each piece of the pie could be slendered down and in so doing, provide not 16% of our population, but a
10 bigger percentage of the merging middle class with health, I believe that.

PROF FONN I suppose I'm following the track that Dr Bhengu had started which was you sit in a very useful position for us, because you're not in the hospital sector and you're not in the private sector and so your opinion might well be less inclined to tend towards one or the other and I think you've answered that. My next question was going to be and do you know who might be getting more of the fat
20 and you're saying ag, everyone's taking a slither if I understand you correctly.

I wanted then to pursue a question that Dr Bhengu has already asked, so I want to take it one step further and that was the question of evidence based practice and peer review and those kinds of things. You said that it's possible to operate completely

external of any of those kinds of checks and balances, so then I want to understand what your society does. What is it's role, what should it do, what does it, what could it do, why do I as a cardiologist, become a member of the Cardiology Society, what do I get and the nature of the society, can be two-fold, to protect the status of the professionals, or to protect the profession and where is the society in that regard.

PROF ANDREW SARKIN Okay so it's a very important question and in fact I raised that with our society not that long ago, what is our role as an organisation and

10 in fact I didn't show some of the slides at the end, I got distracted, but maybe we can and I apologise, but the role of the society is to look after the doctors as they explained it to me and not to be an advocate for the patients per say in our country.

I was trying to give today as I will see health and advocate for all in a way. Our society is an advocate for doctors who belong to it, not for their role as an advocate for society, they don't see their role as a thing, so in a way, furthermore, one needs to

20 realise that the health system, that 80% of the doctors, are in the private community and they work within that system and they find justifiable within that system, so although the organisation is very important and it advocates and it does a lot of good, it is not perceived to be an organisation which is there primarily for patients' rights or

for changing health advocacy in the country, or for where the country may end up and that's what I'm here to try and give my personal view.

PROF FONN So then there are 2 other places that this activity could be, which is to maintain the standard of the profession, not the professionals. The one could be the College of Medicine. The other one could be the HPCSA do either, of them play, this role?

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PROF ANDREW SARKIN I don't believe that any you know, unfortunately in South Africa, we have a very, very poor history besides of patient advocacy, which has really been the driver in a lot of countries. I think that the statutory bodies that you are referring to, are primarily involved in teaching and training and perhaps not in health advocacy for the country, although they do have a moral high ground, I'm not trying to underscore that, but I don't think that those organisations per say, see themselves as organisations to try and purely address health advocacy, I don't know

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if I'm answering you.

PROF FONN So I suppose I get that point and I hear what you're saying. I suppose I'm asking around things like peer review, like mandatory reporting of

outcomes, like your suggestion that everyone should do community service at different points in their profession, like using new devices that have only been used within a training environment, who could make that happen, if you think these are desirable interventions, how do we make that happen?

PROF ANDREW SARKIN So I think that all the organisations have been lacking in this and I don't apologise for saying that. I think that organisations that perhaps
10 and I'm certainly, I'm just making a broad sweep without getting into individual organisations, but I think that all of the organisations in our field, have not done enough I believe and I've been quite outspoken about this. I don't think that we've done enough to, I think it's unacceptable that many of us work within the confines of a private practice without giving any community service back, or training or teaching, I don't think that that and I don't apologise for saying that.

20 I think that unfortunately, if it is only up to goodwill in terms of device industry in terms of reporting, those things don't happen and I think that's why most countries have come to regulatory frameworks.

PROF FONN So I do interpret what I thought you were saying, do I interpret you correctly, to be saying that private, in this case cardiologists, but it could be other specialists, are under-regulated in South Africa?

PROF ANDREW SARKIN Absolutely in terms of quality of care, not only cardiology, across the board, we are not well enough regulated and accounted for.

PROF FONN Okay the other question I wanted to make sure I understood

10 you correctly, when Dr Bhengu asked about coding, you said and I'm para-phrasing, I don't know if I can quote you directly, you said the doctors will get together when they feel they aren't being remunerated properly and then they'll discuss coding, that's what you said and that's what you think their motivation is?

PROF ANDREW SARKIN By and large yes, but sometimes it may be appropriate, I'm not saying it's inappropriate.

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PROF FONN But that's it, what I suppose I'm asking to make sure I understand, is the link between coding and remuneration, that the two are integrally linked.

PROF ANDREW SARKIN Ja I stand for correction, I'm not sure that there always is, the coding equals the remuneration, but I know that when the doctors get involved by and large, in their mind-sets, it's to do with the remuneration issue.

PROF FONN Then the question about these new devices, that whomever brings in and you made the point that they are not introduced through usual channels, first into a teaching environment, some research around it, training on how to do it etcetera, so they come in through some other way, where do those doctors learn how to use that device when it arrives? What happens in that environment?

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PROF ANDREW SARKIN So very often a device will come, I'm talking once again, I'm just giving from my term of reference which is my area, but the devices would come in because the company that is the local distributor of the international company, would have a device and they realise that there is a market that could be utilised so to speak and they would obviously do their number crunching and realise that there is by and large, a commercial you know value to the product and bring it in and they would then hone in on a few, what they call key role players which not necessarily and I might without apologising, necessarily are always the right places and very often, it's not through the ways that traditionally it has been, because now

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remuneration has become a bigger issue and profit than where it should be brought in, because I believe that new devices and research and especially if it's not properly regulated from out of the country, which they sometimes aren't, they are not bring in necessarily through the training hospitals because the remuneration will not be the maximum, so they will often.

So then it's a kind of ad-hoc thing, they will approach 1 or 2 people, they will then
10 sometimes send them for overseas training for example to a centre without any regulation, there is no paperwork attached to this. There is no signing off on a proper training. There will be no signing to say that the person has had adequate training and then it might be and then once it's in the country, it would be person to person, but it's not a very robust process and sometimes, not necessarily in the country's best endeavours, nor in the populations, because the first question would be what is the cost involved, how widely is this thing available, how many patients could it be
20 supplied to, what is the research and the use on this device and what is the safety of these devices.

PROF FONN So I could be a doctor sitting in my rooms and someone can phone me and let's say Tabby was new, there is this new Tabby device would you

like to go on a trip to Chicago, we will pay for you and you can see how it works, then you know if you want to use it you can order through us. Is that the kind of…

PROF SARKIN Absolutely.

PROF FONN And in your knowledge is it possible and again it does not have to be cardiology, but that might be what you know best, is it possible that I would
10 develop a relationship with a provider where there is Tabby 1 and Tabby 2 or Hip 1 and Hip 2 or I do not know whatever, there is various options, but I am loyal to the person who took me to Chicago and the fact that it is more expensive is not necessarily relevant to my decision making.

PROF SARKIN Absolutely, and it should not be like that and it is. So Dr A could have an allegiance to company A because they make X valve and company B would
20 go with another doctor so that Dr A has only experience in implanting device A, like Tabby. You brought it up. So that valve that doctor would have preferred, that company would have preferred providers and not necessarily on always because for example a certain valve may suit a certain patient better for example. Even worse is that the public sector and the training hospitals may not have access to it.

PROF FONN And then I wanted to clarify one other thing. You said that in general in a practice one should be probably operating on about 20% of normal people. So this is because your diagnosis was not spot on, I assume or something like that. Is that internationally benchmarked, how do we…

PROF SARKIN Absolutely, so in my field there has been a recent, there was a big investigation in the United States because they looked at it and said you know, about 10 to 20% of coronary angiograms would be performed on normal people or normal arteries. I am just giving you my field. But it does not mean that is abnormal because if you do not over-select, so somebody comes along in heart failure and their heart is not pumping one of the common reasons would be that their arteries are blocked. So it would be reasonable to say that patient needs an angiogram because if you find that out you can improve their life and their heart function so that would be a reasonable thing. So it has been accepted for many huge studies and if anybody leads these it is the cardiac community; we have a hundred thousand patients in many trials following up these so we well know what is an accepted normal thing.

And for example in our area it would be accepted that about 10 to 20%. I can tell you know in the public sector we under-do. There is virtually not a normal patient

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who ever gets into the angiogram because there is such a burden of disease that we have to sub-select. So we under-do, bluntly put we way under-do. One of the medical aids has realised and I went to a presentation that the doctors are doing a huge amount of normals. Now that does not mean that they are normal, but it means they do not go on to another procedure which means that they did not need to necessarily be done and in order to sort this out they have engaged now in remunerating in other ways because they have realised that the doctors will carry on

10 this. So they have changed their modelling. In fact to pay for alternative strategies to come up because it is cheaper for example than doing angiograms. So they have realised that it is cheaper for them to actually do another test which is cheaper than to do the angiogram, so to try and find a cheaper middle range. So there is no doubt that there is over-servicing, there is no doubt about it whereas in our community we find the ways to really in a public health system because I get very upset with the chaps if they are doing normals, you know I want to know why because we have got

20 such limited resources whereas there it is just totally unregulated to be honest with you, it is unregulated.

PROF FONN Two more questions. The one is on the notion of task sharing – doctors are I think all of us we can admit to being little bit of turf-protectors – the

degree to which you believe that we could or should be exploring alternative providers, back referrals to GP's for continuous care, cardiac nursing doing things, a whole series of potential interventions, is there a place for that in South Africa?

PROF SARKIN Absolutely.

10 ***PROF FONN*** And why aren't we doing it?

PROF SARKIN Okay, so it is very important question. You know just to give a little bit of background – when I was a little boy my late dad used to fly up to Malawi and do the fracture work because there was no orthopaedic surgeon in the whole country and in three weeks all the fracture work was done by orthopaedic technicians and in fact because there was limited resources and in fact I have introduced at Steve Biko a system where we really to get in there you have to be triage pretty well.
20 When you are in private practice if a patients' got chest pain then you accept them and you analyse them although ten to one you know that a lot of them that walk in the door, from the moment they walk in you know that they are going to be normal, just you need to look at them by and large. We do not have that in the public sector.

So we have got, there is no doubt about it, we could do much better as a country, not from a financial model but from a health provision we could do a lot better and we are not utilising the people that we do have adequately in our country, there is no doubt about it. So you could have the technologists and we have got a big training at Steve Biko of cardiac technologists, they help with the echos. Not everybody has to see a cardiologist in this country, it is not feasible and that goes for every other area, I am just talking in my area. So to answer your question it is a total poor management
10 of resources that you have got so few people in a country, so well qualified and they are sitting and doing you know huge amounts of people that do not need to be seen by them and could be done at a much lesser level of training.

PROF FONN So then just to ask you, so you have told us how many more cardiologists we need, has that data taken into account the fact that actually we could shift some of the care to other people and to your knowledge is there any research on that with some numbers?
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PROF SARKIN So I do not have actual numbers of that, I can tell you know from a practical model, and I am busy involved setting up a big pilot for this for the NHI, but to come to it is that I have no doubt that there is ways. We do it, because all the

patients that go for example from Nelspruit, we do not bring them all down, there is not even a cardiologist that screens them. We have a radiologist that does the echo assessments for the heart and if they are positive then they come to Steve Biko. So you do not have to have every person coming and seeing a cardiologist. From a health strategy and that should be run to come back to what perhaps rather than coding, academic hospitals should say how can we better sort out our modelling of the country with our expertise and we could do a hang of a lot better if we all bang
10 our heads together – that I have no doubt about. And we have already got, I have got modelling of that. Now other countries have done it, I can tell you now I do not know whether it is well published but there are countries in similar boats to ours that run health with a much more basic and referred a much for clever way, even the National Health in Britain does it much better than we do it.

PROF FONN Then my last question, I just want to make sure I understood this
20 properly. You said to us that many people, at least some of the people who land up dumped on the public sector will be someone who has a few months left to live and while they were in the private sector they got a pacemaker and they have outlived the battery and then they land up with us. Are you suggesting, I mean it is very nice to help someone to live longer and I am not suggesting the doctor was you know, but

are you suggesting that that could be one way of understanding supplier induced demand. That in fact someone was already pretty close to the end and they had an intervention that was very expensive and one should have thought about whether it was rational or not.

PROF SARKIN So there is probably not a health system in the world that has enough money any more to deal with health. It does not matter where you look at it.

10 I went to a talk by a visiting academic who was originally from China, now he is running at Harvard Health Economics. Health is the one area where you can spend a lot of money and get very little back. You can chuck money at health and get very little back and in our area I can spend R100 000,00 in theatre and the patient dies the next day anyway so we have got to be cognisant of that as a country. There is no doubt about it. Having said that, there is no point in putting in a device when the patients' life expectancy is very short and those are things that a country has to, as a

20 country balance. We all balance it, and I do it sadly every day and we try and be fair on what is reasonable in a way. At the moment in our environment we way under-provide sadly in the public health. The opposite may be that there is no long term provision in the public. So if you go along and you are on a medical aid and you are deemed to need a device you will get that whether it is sustainable for the individual

or the medical aid or the country, none of that is taken into account. I do not know if I am answering you.

PROF FONN Thank you, I am done.

10 ***DR LUNGISWA NKONKI*** Thank you Professor Sarkin. My first question is around one of your slides you put up on state public health system and on that slide you talk about how the private sector has grown and continue to drive and you linked that to the perceived lack of efficiency in the public sector. I would just like to know from you what could improve that perception because to me the fact that you label it a perception indicates that at some level you do not think that it is completely true, so that is my question.

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PROF SARKIN That is a very good question. So I think that there are major challenges and I do not apologise for saying that in public health. I think that there is a lot of goodwill, or good work rather than goodwill, that gets done in the public sector. There are some major shortcomings and some of it is perception. The media

has perceived that public hospitals, because of some catastrophes and some big problems of not enough resources, overcrowding, not enough expenditure has correctly perceived very often that the public service is a problem, public health. There is equally and I think the public service and public health have got big issues but there is beyond that a perception about the tragedies that go on. And I think that some of it may be unfair perception to be honest with you. I have got a tiny little department, there is only two of us consultants, Dr Nairn and myself we are the only

10 qualifieds, we did 5 800 cases last year. With that we had a ward mortality of 1,2%. 1,2% dies in cardiac and 8% in ICU – it was small numbers. I run it on trainees, on cardiac technologists which panel member asked me about. So these are not qualified doctors and yet we run an enormous system. We put in 100 new pacemakers, we processed as I said 5 700 people last year, and we had an incredibly and I will challenge any private organisation to show we those kinds of mortality, but those things are not advertised. So the state does do a lot of good. Do not get me

20 wrong there are major problems and there is excellence, there are pockets of fantastic health, there are major problems and I think that we would be naïve not to admit that there is, but I think that there is also a under-realisation that there is a lot of money spent on private health and not always does it translate into outcomes, nor into data

and nor into necessarily appropriateness of therapy. I do not know if I am answering you.

DR LUNGISWA NKONKI Thank you. I just want to follow up on that. So you mentioned that there are pockets of excellence and you would agree that public, no

10 training hospitals have been considered, not only Steve Biko but maybe Grootte Schuur and others, as those pockets of excellence.

PROF SARKIN Sure and one must remember, and I do not apologise for saying it, one must remember where did all our graduates come from, they came from training hospitals in this country. They did not come from private practice so they were all trained in the state facilities, that is where our trainees come from and where our

20 heritage still comes from. So it is not suddenly that one day somebody exists from a public hospital to a private and then they snap their fingers and become excellent, there is that built in you know. It is not to underscore the problems, but I am just saying and I think that the state has not been very good about advertising their resources, about showing their outcomes. We read often in the media and I think that

this is a perception and in fact I told my wife who has been on medication that I wanted to stop my medical aid and she got very upset with me and she said to me no, that is not going to happen because you know what happens when you need something. The trouble is that the state system is so overwhelmed very often with such limited resources that you may not steer the right direction and many of us are scared and that is why there has been an expansion of the private health sector in our country.

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DR LUNGISWA NKONKI Then I would like to know, you have presented several examples of cases of people who have belonged to medical schemes and who have ended up in your department, but are there medical scheme members who voluntarily choose to come to Steve Biko because of its excellence? So people who have not run out of funds, but choose to come to Steve Biko.

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PROF SARKIN Okay, so we do procedures that are sometimes not readily available in private sector. I have been approached by some medical aids, could we take their patients and although we have been approached by three recently, and you know because of some of these very expensive things and in fact I have been reluctant because we just do not have capacity. You know I believe that there is so

many ability of the community to treat them in private practice and we are not covering the indigent patients as well as we should be, but I have been reluctant to taking them. I do not know if that answers you. So we do not have a regular thing, and most patients who are on medical cover are reluctant to sit through the difficulties and inconveniences and sometimes they are pretty building nice floor, nice cup of coffee, you know the things that people often see. So very often the public see the hotel rather than the work that goes on behind it, and that is the

10 realism. So very few South Africans at the moment choose even on a medical aid, unless they cannot get something in private.

DR LUNGISWA NKONKI Just one last follow up on the three medical schemes who have approached you. So they would pay for the service, would they not?

PROF SARKIN They would pay for the service, it is sad to be honest but the

20 public service has been extremely poor at billing the private health system. So some of the medicals aids will come along and say no, we will pay in the public hospital to have the ICD put in and some of them will even refuse. They won't pay for a R250 000,00 pacemaker unless it is put in in the state, I get that often. I get a letter to say that we will cover it, but only if it is put in in a state hospital and the problem

with that is that we do not have, when you have got forty in-patients at any one time, with limited resources, you certainly are reluctant to take another person who has the finances and ability and they have been paid for in competition to somebody who has got no resources if you hear me. So I certainly have been reluctant to engage because I really do not think that the current situation where we are so under-resourced to take on funded patients has been un-ideal because basically you are denying somebody else good health who has got no other options.

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DR LUNGISWA NKONKI And your other reason is that you as the state hospital do not have the capacity to generate revenue from it…

PROF SARKIN And they do not bill, that is the realism. They should be billing the medical aids, but in practice they have been extremely poor, the public hospitals, at billing. They are starting to get a bit better because they realised that it could be an income stream, but even then they are so, you know compared to a private hospital,

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where every morning they phone and they say Dr Sarkin can you give me an update on your patient in ICU, how is he doing, how long do you think he is still going to be there, when is he going to get to theatre, how long is he going to be discharged in because we need to let the funder know. Our hospital, and you know generic, would

not get updates, so they are very poor and I think in fact these patients are never billed for. So the medical aids are very happy with that because they have got basically somebody, so there have been major issues and if the hospitals are going to take on funded patients they would really have to up their game in terms of getting the required revenue back into the system. And the last point is that the revenue that would come back does not come back to the user, it goes into central coffers so if a public hospital bills, the money would go back into central coffers – it does not come
10 back to the department to then go and buy another machine or get another employee. So it does not help our department to service a private patient, we get no benefit, it is just another drain on our already overburdened system. I hope I am answering you.

DR LUNGISWA NKONKI Yes, thank you. My next question is a follow up on the issues raised earlier on by Dr Bengu on RWOPS So in your response to him you said this is not a major problem in your department because it is tightly regulated, so
20 I just wanted to know if you could share with us how is it tightly regulated in your context.

PROF SARKIN Well at the moment no one us do it, that is how it is tightly regulated; so none of us are doing any RWOPS in my department at the moment

currently. I have helped you know, in the five years that I have been there, I have helped a couple of chaps personally in the late evenings on very complicated work in the private sector when they have asked me, but we do not do any organised RWOPS but I know that we will need to change in some sort of possibly a very carefully devised policy about how it can be done without interfering in state work and I think it can be. One has got to make allowances possibly for the younger chaps coming up otherwise they will not stay in the hospital any more.

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DR LUNGISWA NKONKI In the past weeks we had both SASCI and DR Jeffry Kings who came to present to us and they talked about how the protocols that are designed by medical schemes or their administrators do not use cutting edge evidence and how they often are then engaged in continuous debates over what is the appropriate treatment for their patients and provided and argued that medical schemes administrators largely focused on cost minimisation rather than cost effectiveness and you here today are talking about over-servicing in the private sector

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– I just wanted to get your view on their positions of no good use of cutting edge evidence in informing protocols regarding cardiology.

PROF SARKIN So you know I think that the medical aids issue by and large, I am talking from my personal experience when I was in practice, the medicals aids issues were largely to deal with cost cutting. I am talking about my personal experience. They are not to do with what is necessarily in the patients' best interests. You know it was to do with the financial thing. The over-servicing that I referred to is not across the spectrum and it is not everybody, I am talking about a broad blanket, you know I think that there could be better usage. I think that in terms of protocols for
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what should be done and appropriateness probably the academic centres would be in an ability perhaps to guide the profession in what is reasonable in the same way we do in the public sector what is reasonable. Not about costing, but about reasonableness of health provision for the country. You know I think that obviously the doctor in private practice is necessarily trying to do what he or she perceives as the best for the patient, but it does not take into account the countries needs, nor does it take into account – it takes into account often financially modelling to some extent
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and the medical aids are also trying to not necessarily without knowing, very often a non-doctor no doubt about it makes a decision down the end of a phone. I used to have that regularly in private practice where the medical aid person on the other end will deny a procedure because of some… We still have that as you have heard from that chap, where it is not medically decided, absolutely.

DR LUNGISWA NKONKI Thank you.

DR VAN GENT [missed a couple of seconds because speaker not talking into microphone]… struggling as do you and you even more than I do with the patients and your what that have been on schemes or just less schemes because they got ill etcetera and we briefly relayed that as dumping of patients from the private sector.
10 There is a number of reasons for that and we touched upon a couple of them and there must be more, there must be maybe ten or fifteen categories of reasons why this happens and I actually I think also internally we sort of struggle to really get to grips on that phenomenon – I know that you mentioned the sort of day to day or month to month insurance being part of the explanation that this happens and then part of the solution could be a sort of lifetime type of insurance, an NHI type of insurance maybe or the NHS system in the UK. Do you have other, have you thought about talking about this with colleagues to get other ideas on how to tackle this problem?
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PROF SARKIN I think that if we could find a way to ask the first thing is that the public sector at the moment cannot cope realistically with the burden that we have got numbers wise, especially in my area, it is a hi-tech area and there are lots of

patients. One imagines that cardiology is some sort of esoteric heart transplant, it is common, many of us are going to get it and many of us are going to be. So it is a common condition. The only way is that there is some sort of a collegiality in taking the country forward.

I believe that the doctors should contribute one day a week to propagating that. I believe that the medical aids need to do some, not sitting and fighting about how to
10 make maximize their profit or the company that runs them, but to try and say as part of the country we would like to contribute to a bigger percentage of our country in a more holistic way and find solutions. And the month to month as I mentioned, because that is how I see it, it is a month to month, it is not a sustainable model so we have to look at it holistically and I think that the NHI is really an attempt to look at the sustainability of all of that. I read recently the cost implications which are really quite massive that are being bandied around, sort of R340 billion I saw bandied for
20 this NHI project. I do not see it only as a costing issue, I think that there are, how I see it and I am just giving it to you as not an economist but I do not believe that we are Sudan or Ethiopia that does not have health resources. We are spending a lot of money on health as a country, we are spending. The WHO suggests 5% of your GSP, we are spending 8,3 I understand or above 8% so we are throwing a lot of

money at health, I do not see those outcomes on a day to day level – I see terrible outcomes every day I go ward round and I am exhausted. I start half past seven, six o'clock and I just see tons of patients that were on insurance, that are no longer on insurance. So I think that we do have enough resources, we have enough people, we have enough hospitals, we have enough ability, expertise and I think we can merge that all if everybody is honest with each other and find solutions. I do not know if I am answering you.

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DR VAN GENT [missed a couple of seconds because speaker not talking into microphone]… that should be done, of course that should be. The first step in this context I think is the first step would be awareness of the problems.

PROF SARKIN Sure and I have tried to relay that.

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DR VAN GENT They are very good to you, you gave the clip which is a good idea to do that and also you gave us a number of these examples, very brief examples.

PROF SARKIN Cynically I do not believe that goodwill is enough. I think that we need to regulate and you know that is the second part of your question, I would and

the last few slides I have left out but I will show it to you. So I believe that for example cardiologists should be given twelve months to twenty four months as a community and now people are telling me that they are going to be very upset with what I say, but I am giving you my personal view. I believe that each grouping should be given a finite period to come as a community with their academic department to find solutions to their area and if they do not come within a finite period to contribute to health, then it should be regulated and I sadly think a

10 regulation will be necessary because unfortunately we have moved as a country to beyond only... It is alright for Scandinavia and Norway and Holland to have goodwill because they [inaudible 2:31:30], but I think in our emerging country money has become very important and goodwill has kind of, the ethos and health has been caught up in all of this. I do not know if I am answering you.

DR VAN GENT Yes.

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PROF SARKIN I mean short of regulation we are not going to move on.

DR VAN GENT I read your recommendations of course in your submission with great interest, you are sort of trying to find a solution in the public sector - let doctors

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from the private healthcare sector come and help us sort actually the problem of dumping. So they provide services in the public sector for one day a week etcetera, so then we can sort it out. I am also thinking of finding solutions in the private sector because the private sector is the core of the problems actually of this problem is the private sector and I am looking at your, while you were presenting the two clips and I read also the submission with the tables of about twenty five or thirty short stories about patients I thought it might be maybe, it is creating awareness of the problem.

10 We have been confronted with this problem throughout the enquiry now, but all very sort of hints of a problem and now we have this list of people and I was thinking and maybe we should not make decisions with it now, but thinking of having these stories written up as evidence for our enquiry you know in a structured way and see what happened to Mr A, B, C and D in your ward. Maybe think about it, you do not have to and also we have to think about it. Maybe that would serve our purpose, but I do think it would be very tangent evident of what is going on.

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JUSTICE SANDILE NGCOBO If the gentleman involved with that is prepared to make an affidavit, that is what he says in his letter.

PROF SARKIN Yes.

DR VAN GENT Probably a person that would agree with that and have eight to ten people do the same and make it a sort of real convincing statement that this is happening and what the problem is for the public sector from that.

PROF SARKIN Sorry Judge, just to come...

10 ***JUSTICE SANDILE NGCOBO*** Do you have the document?

PROF SARKIN Yes, I have got it here.

JUSTICE SANDILE NGCOBO This is where you have just given a story about what each of the individuals what happened there, are these the individuals who were treated?

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PROF SARKIN Yes.

JUSTICE SANDILE NGCOBO At your hospital?

PROF SARKIN Sure.

JUSTICE SANDILE NGCOBO By yourself?

PROF SARKIN Yes, absolutely. Each of those is first hand knowledge.

JUSTICE SANDILE NGCOBO So you have got firsthand knowledge of the facts that are stated here?

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PROF SARKIN Yes, and a lot of them yes and this is over a relatively short period because when I saw Dr Motsoaledi he asked me if I would keep, he said he needs if you know some patients and, this is just a tiny fraction, I can get you any week more of them.

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DR VAN GENT Can we come back please? It is a matter of organising it. The second issue that I actually surprised you talking as a medical specialist as a doctor, so relaxed about publishing your mortality ratios and your clinical outcomes in your hospital and you must be aware that this is not everyday practice that medical specialists are so relaxed about publishing clinical outcomes and mortality ratios. I

have been responsible for that in the Netherlands for a couple of years, we have an extensive system there and there is a lot of resistance to come by also amongst doctors and rightfully so. It is understandable because of course for this data to have an actual meaning you have to correct for a case base of course and you have to sure that the registration of data is correct, that the metrics are correct etcetera so there is a whole story behind it. Can I first share your comments that you being so relaxed about lets publish these mortality ratios – is that a common phenomenon amongst
10 your colleagues?

PROF SARKIN No, look I am very proud of what we do, I am very proud of our accomplishments.

DR VAN GENT You mentioned as 1,2% etcetera, 8% at wards and you are proud of that – why are you proud of that figure? Do you know this is best practice?

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PROF SARKIN Yes, our patients arrive extremely ill at the hospital. By the time they get to a major teaching hospital they have got a... I mean I do a ward round and one of our consultants does a ward round every day and even one of two of the chaps come from private, [Dr Osra? 2:37:23] he really provides a lot and he always says to

me he is amazed at how ill these people and how they recover and the chaps work extremely hard at it. I drive quite a tough ship, you know I want to know about everybody who is not doing well and we go past and look at them and the chaps, we do – I believe in the unbelievable, and I have got international things to compare it to. So we have just had our two visiting professors working in our department – one chap from Cleveland Clinic who was here and he was amazed at what we do. I mean he spent a week operating with us, in fact I think it was three weeks. So we batch
10 cases as a training for the young guys and he was amazed at the level and in fact he phoned me over the weekend and he said you know Andrew I have been thinking you about you guys do with such limited resources and it is something to give deep thought to. So we do have, I do have some sort of international platform to compare it to.

DR VAN GENT So the first step to compare yourselves with is with these eight
20 colleagues in South Africa – the other teaching hospitals. Is there any initiative? Actually its sort of number 2B of my question on transparency and on accountability. So we talked about how can you be sure that you measure the right things which is obviously quite a complex issue and we cannot deal with it here, but you explained to us that you already can compare yourselves to some colleagues outside. So my 2b

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question, that is the last question – who is responsible for actually taking action here? So there is a number of parties that could be responsible; thinking of doctors, hospitals, medical schemes, the government. My experience is if doctors take the initiative, this is absolutely by far the most effective. First of all for themselves they have to know amongst themselves who is, you know what is right and what is wrong, who is producing worse, who is offering services that are [inaudible 2:40:06] and most of the doctors do not know – you do not actually yourself know. You know

10 because of your international contacts, but most doctors do not actually know how they perform. You explained that because most doctors just drop out of the Universities and go into the private practice then they are isolated. My question is why don't you take the initiative to do this – for example amongst the first of all eight to nine colleagues that you have.

PROF SARKIN Sir, you are raising a very important question. The first thing is as

20 a community that tried to introduce among the private cardiologists an initiative where they would provide self-provide data and in fact it was very poorly taken up and the data was problematic about what was coming out about the country and they were not keen that the stuff is published about how many normals are being done, those kinds of issues as a community. So I think that in a training hospital in my

hospital it is much easier, we do our own stats, but even the public service there is very poor systems in place and everybody is so worried about the publishing because often there are problems that transparency in our country, in all communities public and private, openness and transparency is perceived. I am quite open, I would invite anybody to come in and view it and I believe one should be like that, but I think that the overseas countries that have moved to that, it is because it has become regulated as such.

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DR VAN GENT Well, I beg to differ. I know of these, as I said I was responsible for that too and I had two surgeons visiting my offices when we started this clinical registration of data amongst colon doctors or specialists as a private initiative. Of course they needed a bit of money and they found it with schemes and with the government as sort of co-payment and they needed a couple of years of getting it from the ground, but it was a private initiative and largely in terms of their time they put in, largely also paid for by these doctors themselves. Ultimately they have grow it over a period of time, of six to seven years to twenty, 100% governance and registrations and wonderful results coming out of that, saving lives of course, but it started off as a private initiative funded a bit by the Discoveries or the Government. So it did need legislation, we have the legislation in place, we could force doctors to

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register and publish, we did, but by far the best results came from when doctors realised themselves that they were responsible and even you could I think argue that by law doctors are obliged to publish, to give openness about the product they are offering and the services they are offering. So I beg to differ a bit on the power of the legislation on this.

PROF SARKIN Well for whatever reason in this country we have not realised that

10 and I am not aware of any community, I am not talking about cardiology that is at that level yet of doing it for whatever reasons.

JUSTICE SANDILE NGCOBO Professor Sarkin, just for the record you have furnished us with this three documents. The first one is AS1 which reflects recent cases which you say were patients who were compromised due to lack of funding. This is in AS1.

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PROF SARKIN Right.

JUSTICE SANDILE NGCOBO These individuals were treated at Steve Biko hospital and they were treated by yourself or under your supervision.

PROF SARKIN Correct.

JUSTICE SANDILE NGCOBO So you have personal knowledge of what is stated there?

PROF SARKIN Correct.

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JUSTICE SANDILE NGCOBO Now AS2 it also refers to patient movement to the public sector due to failure by the medical aids to fund the treatment.

PROF SARKIN I would not say failure, but that the patients moved from the one sector to the other because of a...

20 ***JUSTICE SANDILE NGCOBO*** I am just reading what the document says.

PROF SARKIN Sure.

JUSTICE SANDILE NGCOBO Do you know the document?

PROF SARKIN I know the document.

JUSTICE SANDILE NGCOBO Now, the list that is provided there, the names that are there, these individuals were treated at your hospital?

PROF SARKIN Exactly.

10 ***JUSTICE SANDILE NGCOBO*** So you have personal knowledge of all of these?

PROF SARKIN Correct.

JUSTICE SANDILE NGCOBO So last one is AS3 – that is the gentleman who has offered to put up an affidavit in support of what he has stated in his letter to us.

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PROF SARKIN Correct.

JUSTICE SANDILE NGCOBO You have personal knowledge of that as well?

PROF SARKIN Correct.

JUSTICE SANDILE NGCOBO Yes. Now you mentioned that non-communicable disease, maternal and I think new and some of these diseases are the measures of how a country is performing on healthcare issues – is that right?

PROF SARKIN Correct.

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JUSTICE SANDILE NGCOBO Why is that so?

PROF SARKIN So one of the measures that a country can do in terms of health provision as a country is look at mothers and infant mortality. So it has been well scrutinised as a parameter of how health services is doing. Mothers at child bearing age and their health around giving birth is a record usually of a young healthy person extensively going into a pregnancy. So it does reflect not only the mothers' health

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but it is a crude reflection on the health of your country. Similarly your infant mortality is looked upon by the World Health Organisation in many countries as a crude index of how you not only your providing curative health, but preventative health in a country in terms of vaccinations, sanitation, water supply. So it does tell

you a bit about- it is broader than just curative healthcare but how as a country one is faring.

JUSTICE SANDILE NGCOBO Is this an accepted standard or measure?

PROF SARKIN Yes.

10 ***JUSTICE SANDILE NGCOBO*** You mentioned that there are at least four provinces that do not have the services of a cardiologist – is that right?

PROF SARKIN Correct.

CHAIRPERSON And you talk about the public sector?

20 ***PROF SARKIN*** I mean provision of cardiac services in the public sector.

JUSTICE SANDILE NGCOBO In the public sector ja. What steps if any are being taken in order to overcome that?

PROF SARKIN First of all I am not a spokesperson for the National Department of Health or the Provincial Health, I am just going to give you my personal things. They do have a human resources schematic so these provinces are all supposed to have personnel to service cardiology and the posts are advertised in the newspaper as they are supposed to be in the Sunday Times periodically and they have a post open and they have it. First of all how far in pushing that agenda I am not sure always happens, just to answer. Second of all it is not very, there are obviously limited

10 people that are you know in the country, that are eligible. Because I mean if you are dealing with a pool of less than two hundred people, there is obviously a relatively small pool of people within the country. How far they pushed that in terms of looking for somebody, advertising it nationally, going and headhunting somebody, making it attractive, I am not sure. I think more could be done, to answer your question.

20 ***JUSTICE SANDILE NGCOBO*** Based on your experience as a cardiologist in this country and also who is involved in the public sector, does the public sector have the ability to attract and retain specialists?

PROF SARKIN So I think that the question you know is a very heavily loaded – it is a very good question. I think that to answer your question the public sector has a lot to offer so if you ask me you know what are the attractiveness for a person like me to be in the public sector – first of all you are part of a University and you are training and giving back to the next generation. I go home and feel, when I have seen patients I feel that I have been productive and I have contributed not to one person but to a broader substantiveness. Everybody that I see or contribute to is very ill and

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I contribute, I hope, a lot – not only to that immediacy of that patient, but to the next generation and the future people and to the undergraduates. So I think that there is satisfaction beyond only financial remuneration and you know, so that is it. I think that there are a lot of challenges in the public sector and frustrations and sadly a lot of the doctors have left the public service angry and feel that they were let down in a way of how they were used, they work long hours, they felt their remuneration was insufficient and I think though but there is a lot of good that one is providing in health. I do not know if I am answering you in a roundabout way.

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JUSTICE SANDILE NGCOBO Does the public sector have the ability to attract specialists and retain them? You mentioned that some of them are leaving because they are unhappy, they are unhappy about what?

PROF SARKIN So they feel that their remuneration and working conditions in private practice is superior to what it is in the government sector. They make more money and they work in a nicer hotel and they will be able to have a better lifestyle and a better car and etcetera and build up a bigger nest egg for later in life. Is the public sector at the moment able to retain and attract people? Yes, there is the odd person who remains. Is it able to sustain this in its current model and build on it? Unless things change, it is not expanding and developing and able to retain enough

10 no.

JUSTICE SANDILE NGCOBO In response to the suggestion that pockets of excellence in the public sector that you mentioned are to be found in academic hospitals – what prevents the public sector from extending that to other hospitals?

PROF SARKIN In the public sector?

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JUSTICE SANDILE NGCOBO Yes.

PROF SARKIN Not in the private sector? So I think that there has been a lot of, to be honest with you, at local hospitals I think the management could be better. I am

not talking about our hospital, I am talking now in a broad sweeping statement. I think the public service, a lot of the things that affect employment and people's options could be better managed within it. A lot of that is not policy in the country, it is micro management at hospital level and I think that the public sector could do a lot better at the micro level of the hospital. This is not current policy of the country or provincial, it is actual local management is often not in tune with the needs of their hospital and they do not... So that is often not propagating, the system is long

10 winded, you battle to get equipment, we have been waiting sometimes three years for a piece of essential equipment. The chaps suddenly do not get paid for a month or two because they are overtime forms is delayed. So those are, they searched when they come in and out of the hospitals, they do not get a cup of tea, we do not get any coffee or tea. Now those are minor issues but the chaps go out and they get all swooned and they get nice offices and a carpet and air conditioning and tea – no I am being realistic – and I know those are not issues on the ground, but those do make a

20 difference and if you want to retain doctors in the public health service they will have to, and I am not talking about our – do not get me wrong, not Steve Biko – the public service will have to put their game. I do not know if that answers your question.

JUSTICE SANDILE NGCOBO [inaudible 2:55:55 to 2:56:29].

PROF SARKIN That is a good question. So in fact we have got, I mean the problems that we face in health and perhaps that you are going to have to deliberate are a reflection of a very divided economic country, you know which is a country of two extremes, perhaps like Brazil's got and we are trying to grapple with the problems of inequality financially. So if people have got money then they will access
10 the health or they will pay for provision because that is what it is, it is a commodity perhaps.

I have tried to say that this is perhaps a problem beyond that for health, perhaps not like other issues. But of course it is an issue of inequality in a country where you do have enormous inequality in segments of ones population. So is it realistic? Yes, I do believe that one can move a country forward and move the people and the doctors
20 and the health insurance and the public sector in a main that in twenty years we could be sitting here and say that we have changed the outlook of the peoples' health of the country, I do believe that. Maybe I am an idealist, but I do believe that that can happen.

JUSTICE SANDILE NGCOBO [inaudible 2:58:01 to 2:58:05]

PROF SARKIN That is a very important question you are raising.

JUSTICE SANDILE NGCOBO Because that is where it starts.

PROF SARKIN No, you are 100% right. So do we as a, and I am engaging most of the medical students at a later period, do we engage them in the ethos of what the
10 profession should be about? Perhaps you can go to the last slide just to show them? I do not believe so, perhaps the University will be upset with me for saying that or anybody and perhaps I am really, you know how much ethics we train them in, but just you know do we engage in the ethos of what we are there as a health community well enough and do they leave medical school feeling that they need to give back into the community or rather better question is do they have that ten years later? Certainly they do not leave ten years later. A lot of the medical profession go into
20 private practice upset, angry and not feeling part of the country and whether that is a manifestation of a bigger country issue, or whether they have just become much more egocentric I am not sure, but I do not we do do enough as a country to answer your question, nor at the medical student level we do not. I do not believe we do.

JUSTICE SANDILE NGCOBO If ideology for example take the view that it is not their job, do we advocate for patient, the very people whose lives they are supposed to look after. That cannot be the correct attitude is it?

PROF SARKIN Well I think the country has emerged in a way, you know with this whole... I think that engaging with people that I come in contact with, non-doctors, people do not see that if you cannot pay for health why shouldn't you be able to get it. You know that is the country that we have engaged in – that is the way I see it – I am giving you my personal view, but the average person that one mixes with will believe in our country. Well, you know there is nothing wrong with what we have got going, obviously that is the more affluent part of the community that believe that, but the media portrays that, but there is nothing wrong with the system that we have got and I think that a lot of the doctors have slowly bought into that over the years and there is an argument that I am not making, that is made, well what is wrong with it – you have got this system and that system, if you can afford this then you go for that system and if you cannot afford it then you rely on it. I do not accept that as I have tried to portray here, but I believe that it is an ethical issue and we have done something wrong. Maybe just the last slide, it just was a little slide, there were a few

others but I just wanted to show you. Go back to that one, no go back other way. Ja, this one.

This was a statement, you know I had to give a talk on this recently to our medical community. I spoke on this topic to the cardiologists of our country at a recent meeting and I ended up with a slide which was by a very famous physician in the Middle Ages "I am not about to apply myself to the duties of my profession, support

10 me in these great labours that they may benefit humankind, inspire me with a love for my art and for your creatures, do not allow thirst for profit, ambition, admiration to interfere with my profession, for these are the enemies of the truth and can lead me astray in the great task of attending to the welfare of your creatures". That was by Maimonides in the Middle Ages, but I think that we sort of need to re-instill at our younger people the values of what we are there for as a country.

20 ***JUSTICE SANDILE NGCOBO*** I think it would be a good step if there were to be co-operation between the private sector and the public sector in the provision of healthcare as you are proposing, but have you given consideration to how that might translate into reality, how that partnership could work in practice.

PROF SARKIN So asking it actually only happens at the moment by and large by the goodwill of the private community. So when I get a chap from private practice to come in and help the chaps, you know some of them say I do not want the money from the hospital because it is not even my petrol money although they do get it, but a cardiologist will charge upwards of R5 000,00 an hour for example to be seen. The state do not remunerate at anywhere near that on a sessional post so the person has got to at the moment do it because they feel some sort of personal reward or they feel
10 they are contributing, financially it is not worth their while at the moment and in fact some of the chaps... I mean I get a chap from Johannesburg who is a cardiologist who comes in to help with a very specialised high difficult procedure where we blow the valves open for somebody who is dying and there is only a few people in the country who can do it and he comes and he says to me, no Andrew on a Friday afternoon, I pick him up at the station, he comes up to the hospital, we do about two or three of these young very ill people and he goes back because there are
20 none of these in private practice, they are virtually all in the state these people and he enjoys the procedure. He has done it and he is very good at it. So the point about it and he says to me you know what Andrew, I do not want to hear about money or the little bit that you give or that the state will give me, it is not worth it. So financially the current model, I am not saying that the state has a lot of money, but for the

amount that these people are earning in a private sector it is really not worth their financial while to come. It has got to be more than that. They have either got to do it because they get some personal gratification or they feel they are part of a bigger mission. So the current modelling – now whether the state could afford to compete at those salaries is probably doubtful at the moment. The state believes that they pay quite good salaries, they believe that, I know that because they are on record as saying that we pay you, and I am not saying they do not pay reasonably, but there is certainly a big gap in what the private community earn and what state sub-specialists would be paid. How you bridge those or how do you bring them into line, whether it is a remuneration or a carrot or a stick in terms of regulation I am not sure, but there has to be a moving together.

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JUSTICE SANDILE NGCOBO Yes, I understand. Is there anything else that you would like to add to what you have told us?

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PROF SARKIN I have covered most of it. The last few slides were really just a summary of how to maybe idealistically, but bringing everybody together that hopefully all role players could come together.

JUSTICE SANDILE NGCOBO I had a question, but I think you have answered this question – to what extent does medical training prepare doctors for community service? The kind of ethos that you were talking about, but I think you said no, it does not.

PROF SARKIN You are talking about the ethos? It is not the practical how do you manage hypertension, which drugs... I think we are very good at that. How do

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we and have we engrained enough of a belief in the holistic part of the country, well I think the outcomes at the moment are showing otherwise. If we were, I am going to turn it around, I think as a country if we were engraining that country spirit we would not have the discordances of 80% of doctors in private and 20% in public because hopefully... Although money has a guess and that is the biggest motivator, I really do believe that it is mostly besides work conditions it is a financial issue.

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JUSTICE SANDILE NGCOBO Is that what is comes down to?

PROF SARKIN I think it is both. I think that people are tired of frustrations in the public service, the income differential is much bigger and it is that all compounded together that has allowed our country to evolve in the way it has. This is not a long

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term thing, only the last twenty years. I have seen it in my career, the change and the evolution.

JUSTICE SANDILE NGCOBO I understand, thank you.

PROF FONN I mean there has been a lot of research on this, on the push pull factors between the public and private sector and certainly remuneration is an
10 issue. It is also the case that it is a combination of issues and that at no point, when certainly research was discreet choice analysis has been done, sometimes people would choose a lower salary if they worked in wards that were well functioned, well supplied, clean, where there was a collegial relationship, so it is more than just money.

PROF SARKIN Absolutely, and one thing I did not mention was that sadly
20 sometimes they do not even, the state claims they do not have posts so although one reads that there are many unfilled posts when you want to appoint somebody the bureaucracy which comes down to the same – it is not only money. You are 100% correct. It is work conditions, it is money, it is frustrations and ethos – it is a whole big pudding.

JUSTICE SANDILE NGCOBO Thank you Professor Sarkin for taking time to come and talk to us and thank you for agreeing to move your interview half an hour earlier.

PROF SARKIN It is a pleasure and I thank the panel for taking the trouble to hear us and hopefully my views. Thank you.

10 ***JUSTICE SANDILE NGCOBO*** Thank you very much. Tomorrow at... Nine o'clock tomorrow morning, thank you.

... [END OF RECORDED PROCEEDINGS]....

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