COMPETITION COMMISSION MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

Medscheme's Response to Public Submissions

For Public Use

March 2015

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A Member of AfroCentric Group

medscheme

INTRODUCTION

On 5 February 2015 the Chairperson of the Panel of Inquiry provided all participants with the opportunity to respond to the publicly disclosed submissions, limited to the following grounds:

- Correct any information or data that the Panel might rely upon and which we consider to be inaccurate;
- This also applies to correcting any methodology or economic theory advanced in any submission that we consider is inappropriate to apply to available information or data, and which would produce erroneous or misleading results;
- In addition to the opportunity for the correction of inaccurate or misleading information, particular parties against whom specific allegations of fact have been made or adverse conclusions asserted, may wish to respond to such allegations and assertions.

Whilst Medscheme is acutely aware of the need to keep all responses factual and succinct, there are certain underlying themes and assumptions made in the collective submissions that require rebuttal, to ensure that all issues are fully considered and ventilated before the Panel.

1.1 Value of Managed Healthcare

It is alleged in more than 1 (one) submission that fees for Managed Healthcare only adds to the non-healthcare expenditure of a medical scheme and that such management of a members' healthcare should fall within the exclusive control and sole discretion of the healthcare provider.

Medscheme would like to bring to the Panel's attention that currently Managed Healthcare initiatives implemented by medical schemes fulfil a dual function:

- To represent the member during the strategic purchasing of healthcare products and services;
- Cost containment on behalf of the medical scheme to ensure the financial sustainability of the collective risk pool.

Managed Healthcare techniques that partner with healthcare provider services are the most suitable mechanism available to successfully achieve these objectives thereby ensuring the sustainability and longevity of the private healthcare industry.

Managed Healthcare interventions are an internationally recognised and accepted practice for ensuring that only the most clinically appropriate and cost effective services are delivered to the patient.

As evidence of the quality healthcare outcomes and cost savings achieved by Medscheme in their capacity as a Managed Healthcare Organisation, we attach hereto [**Confidential**]

1.2 Professional Autonomy

The framework of professional autonomy needs to be defined as healthcare is delivered within a system of many interrelated stakeholders. Within this context Medscheme would agree that autonomy to make clinical decisions in the best interests of their patients within the context of best practice and evidence based medicine is critical. This would include consideration of cost effectiveness and quality. Professional autonomy cannot imply that a healthcare professional is free to make clinical decisions without any framework through which they can be held accountable.

In addition this accountability is not only applicable at an individual level but should also consider the impact of a decision on a population given the limited resources available to fund the provision of healthcare. Appropriate rationing of care is a universally adopted practice to managing limited healthcare budgets.

[Paragraphs 3, 4 and 5 - Confidential]

1.3 Financial health of the medical scheme industry

It is alleged on more than one occasion that the solvency ratios' of medical schemes and their accumulated reserves are indicative of a funding industry in good financial health. What is however absent from these assertions is the necessity for medical schemes to implement above-inflationary contribution increases annually to ensure such financial stability.

As evidence of this, we enclose the below table indicating the applicable percentage contribution increases for the largest open medical schemes in the country between 2011 and 2015:

	2011	2012	2013	2014	2015	Average
Discovery	7.9%	8.9%	10.9%	8.9%	9.9%*	**9.3%**
Bonitas	9.6%	8.4%	9.9%	10.6%	7.2%*	**9.1%**
Medihelp	15.9%	8.9%	11.2%	10.1%	8.5%*	**10.9%**
Momentum	7.9%	8.8%	7.9%	7.2%	7.9%*	**7.9%**
Medshield	9.5%	16.0%	7.5%	9.4%	9.5%*	**10.4%**
Fedhealth	9.7%	7.1%	7.9%	8.9%	10.6%*	**8.8%**
Bestmed	11.4%	9.8%	9.0%	9.3%	8.6%*	**9.6%**
Liberty	12.8%	10.0%	11.0%	9.5%	10.4%*	**10.7%**
Average	**10.6%**	**9.7%**	**9.4%**	**9.2%**	**9.1%**	**9.6%**

* Note that these are published figures.

1.4 Ability of Hospitals to influence the Level of Care received

A few submissions to the market enquiry have made reference to the limited ability of hospitals in influencing the level of care provided to patients. This is given that the treating practitioner controls the care pathway of a patient.

Whilst Medscheme is not in a position to provide substantive supporting evidence to the contrary, we are familiar enough with the intricacies in the healthcare supply chain to recommend that the Panel unpack these contentions further, specifically with reference to over servicing and the incentives (or lack thereof) to manage the cost of care effectively, even if only within an ambit of partial capability. Areas of consideration could include:

- What influence does the hospital have over the level of care, given that it employs nurses and nursing agencies and it thus has control over part of the entire care pathway? Access to skilled nurses would have a positive influence in terms of the appropriate use of hospital facilities, however the counter also applies. Nursing shortages and a lack of skilled nurses would impact on the ability of the hospital to manage the delivery of care in an appropriate setting which in turn will drive up costs due to over servicing;
- What role does the hospital play in influencing the level of care due to its procurement strategy in terms of equipment, medicines, surgical and consumable items? What is the requirement on the hospital to provide practitioners with the latest technologies, and does this influence the level of care provided within the facility? Do practitioners own equipment within a hospital and does this further influence the level of care provided by the hospital?
- Specifically for doctors consulting from the hospital premises, what freedom do they have to perform procedures in their rooms and is this alternative level of care permitted by the hospitals?
- In addition to the frequent engagement with the Medical Schemes, what influence do the case managers within the hospitals have in driving effective utilisation of hospital resources including effective discharge planning?

Medscheme notes the comments in the submissions detailing the role of the treating doctor in determining the level of care provided to the patient, however it is not inconceivable that the hospitals do have more than a limited influence over the level of care provided. Over servicing may thus occur where a hospital is not able to manage, or elects not to manage the specific service points including:

1) Appropriate level of nursing care provided at the appropriate time;
2) High cost technologies managed in terms of strict policies and guidelines;
3) Procurement strategies focused on most cost effective care;
4) Providers encouraged to make use of day-case facilities; day theatres and procedure rooms in their own practices;
5) Administrative staff within the hospital act efficiently in terms of time billable based activities and discharge planning.

[Section 1.5 - Confidential]

SUBMISSION SPECIFIC MISLEADING, INACCURATE OR ADVERSE STATEMENTS

As per the opportunity afforded to participants by the Panel, we shall now respond to any submission that Medscheme identified as containing material inaccuracies of facts and information that may mislead the Panel into incorrect conclusions, alternatively that constitutes an adverse allegation against us. For ease of reference we shall consolidate our reply into the respective healthcare groupings.

2.1 Hospitals

2.1.1 Mediclinic

Page 103 Paragraph 4.9.3.5.3 – Funding criteria for new technology

"New technology will only be funded by the medical scheme if there is no cheaper alternative available (albeit inferior treatment modality e.g. where laparoscopic surgery may be the less invasive alternative resulting in faster recuperation, if the open procedure proves cheaper than the laparoscopic surgery, the laparoscopic surgery would not be approved for full payment). For example, schemes administered by Medscheme and GEMS do not pay for laparoscopic procedures except for laparoscopic cholecystectomies. Laproscopic appendectomies are excluded completely across the board from all GEMS options. This is a decision based only on medical scheme costs and the patient's preference for a shorter stay or employees sick leave absence is not taken into account in the value proposition."-sic

This statement is factually incorrect.

New technology is considered for funding sufficient clinical evidence is available to confirm its safety, effectiveness, as well as affordability compared to current technology/procedure in place. If the prevailing evidence suggests no substantial medical value for the new technology compared with cheaper alternatives, funding may be declined. However there are situations where new technology has been proven to be safe and effective with improved outcomes, or has provided a treatment option where there was nothing available before (e.g. artificial heart), but because of significant incremental cost, the scheme has decided not to fund, or only to partially fund. These technologies may then be declined, made available with a co-payment, or funded on ex gratia level for selected cases.

The schemes to whom Medscheme provide Managed Healthcare services, including GEMS, pay for many laparoscopic procedures other than laparoscopic cholecystectomy, including diagnostic, bilateral or repeated inguinal hernia repair, appendectomy, colectomy, female sterilization, Nissen/Toupey, removal of adnexal structures, ovarian cystectomy, myomectomy, removal of

ectopic pregnancy, cervical/thoracic sympathectomy, orchidopexy, nephrectomy, adrenalectomy, renal cystectomy, bilateral varicocelectomy, recto-sacrocolpopexy and prostatectomy. For a minority of these procedures criteria and/or co-payments do apply, and schemes may require that the more technically difficult procedures are performed by surgeons identified to be experienced and/or operating within a multidisciplinary team/centre of excellence.

GEMS also funds laparoscopic appendectomies for women of child bearing age and obese patients. Literature does indicate a shorter hospital stay (by about 1 day or less) and earlier return to work (0-7 days) for the laparoscopic approach, although for a member to experience these benefits a schemes must pay more than double the price of an open appendectomy and it is therefore important to control the cost by selecting the most appropriate patients.

[**Confidential**]

2.1.2 Day Hospital Association

Page 6 Paragraph 4.12.1

"According to Medscheme, 75% of all surgical interventions can be attended to safely in a day clinic."

This is not correct. In a presentation given at the DHA conference in September 2014, Medscheme indicated that internationally 60-80% of all elective surgery is day surgery. In addition we provided a list of the most frequent procedures done as day cases – this list constitutes 75% of all day case procedures based on data available to Medscheme.

2.2 Administrators

[**Confidential**]

2.3 Pathologists

[**Confidential**]