



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

National Department of Health: Response to submissions made to the Competition Commission Inquiry Panel

Private Healthcare Market Inquiry

Executive Summary

This document outlines the National Department of Health's (NDoH) response to the various submissions made by Inquiry Participants. The purpose of the document is to provide counter-arguments and responses to the erroneous comments as well as to correct misleading perceptions and claims made by stakeholders.

It must be reiterated that the perspectives adopted herein are motivated by the Constitutional imperative to improve access to affordable, quality healthcare services for all South Africans. Although regulatory issues were raised by nearly all the stakeholders, there are many commonalities across the submissions. This document endeavours to respond to the areas where submissions were most misaligned with a) existing legislative or policy contexts or b) proposed reforms. The Inquiry Panel is advised to engage with the Department regarding any areas where uncertainty remains.

It is particularly concerning that many participants appear to lack an understanding of both the principles of social solidarity, and the need for redistributive justice. These principles are enshrined in the Constitution and are central to redressing the pervasive, historically entrenched inequality. It is expected that stakeholders will have a variety of economic, political and philosophical perspectives, the trend towards a conservative approach that lauds free market principles is concerning, particularly given the internationally recognised failings of the healthcare market. The Department aims to provide some counter positions in these instances and invites further engagement from the Inquiry Panel where necessary.

The foundation upon which the Department's responses are based is the vision for the health sector as outlined in Chapter 10 of the National Development Plan priorities for the health sector. The key focus of the Department's programme of action is to ensure that the country has a sustainable health system through:

1. Greater intersectoral and inter-ministerial collaboration is central to the Commission's proposals to promote health in South Africa.
2. Health is not just a medical issue. The social determinants of health need to be addressed, including promoting healthy behaviours and lifestyles.
3. A major goal is to reduce the disease burden to manageable levels.
4. Human capacity is key. Managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed.
5. The national health system as a whole needs to be strengthened by improving governance and eliminating infrastructure backlogs.
6. A national health insurance system needs to be implemented in phases, complemented by a reduction in the relative cost of private medical care and supported by better human capacity and systems in the public health sector.

The National Department of Health, in collaboration with other government departments and statutory bodies, must implement proactive legislative and regulatory interventions to retain and strengthen oversight over the pricing and competition aspects of the health system. This role is in the form of providing information to patients through interactive mechanisms, not just passive channels; effective anti-market concentration regulation; creating financial incentives for providers to operate optimally; and guaranteeing minimum quality and other

related standards and norms that must be met by all providers, in both the public and private sectors as part of ensuring access to quality health services for the entire population. Mechanisms must be put into place to allow the government to routinely obtain data used by various stakeholders in the health system and must develop and implement systems to make this information more accessible for patients to aid their ability to make informed choices.

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DATE

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1. INTRODUCTION

The National Department of Health is the custodian for the health of the national population. It is responsible for ensuring that certain key principles form the basis upon which the national health system is based, while ensuring that all stakeholders involved in the provision and delivery of health services are provided with an enabling environment that contributes towards a sustainable health system. Such a health system can contribute towards realising the health rights as enshrined in The Bill of Rights in the Constitution as well as enabling all individuals and households access to affordable, efficient and effective quality healthcare services.

The National Development Plan lists 9 priorities for the health sector, namely:

1. Address the social determinants that affect health and disease
2. Strengthen the health system
3. Improve health information systems
4. Prevent and reduce the disease burden and promote health
5. Financing universal healthcare coverage
6. Improve human resources in the health sector
7. Review management positions and appointments and strengthen accountability mechanisms
8. Improve quality by using evidence
9. Meaningful public-private partnerships

The submissions and comments by various stakeholder groupings to the *Health Market Inquiry* traverse many of the areas listed in the above 9 priorities. While it is acceptable and understandable that stakeholders will provide or submit information and evidence that is intended to support their perspective and interests on a particular matter, it is also important that the Inquiry focuses on the notion of **health as a public good**. This is important because the State is expected to put into place institutional, organisational and regulatory mechanisms to support the progressive realisation of the right to healthcare for every citizen.

In assessing the documentation submitted by the various stakeholders, the National Department of Health considered the current policy and legislative environment as well as planned policy and regulatory interventions to achieve the vision of a sustainable, integrated and affordable health system offering quality health services to all.

2. DISCUSSION

The sections that follow provide responses to the comments as well as to correct misleading perceptions and claims made by stakeholders. It must be reiterated that the perspectives adopted herein are motivated by the Constitutional imperative to improve access to affordable, quality healthcare services for all South Africans. Although regulatory issues were raised by nearly all the stakeholders, there are many commonalities across the submissions. This document endeavours to respond to the areas where submissions were most misaligned with a) existing legislative or policy contexts or b) proposed reforms. It is strongly recommended that the Inquiry Panel continues to engage with the Department regarding any areas where uncertainty remains.

a) HOSPITAL SUBMISSIONS

The NDoH aims to respond to specific areas raised in submissions made by, NETCARE, National Hospital Network, Mediclinic South Africa, Life Healthcare Group and Day Hospital Association. These can be summarised as:

1. The regulatory context and need for regulation
2. Issues relating to pricing and reimbursement
 - 2.1. Pricing of pharmaceuticals
 - 2.2. Pricing of services
3. Hospital licensing and Certificate of Need
4. Claims regarding the cost of public vs. private hospital admission
5. Issues relating to hiring of healthcare professionals, including:
 - 5.1. Issues relating to the South African Nursing Council
 - 5.2. Issues relating to the Health Professions Act and regulations including the hiring and training of doctors.
 - 5.3. Issues relating to the hiring of foreign national healthcare professionals

i. The regulatory context and need for regulation

NETCARE's submission included a detailed annexure presenting an overview of the regulatory context in South Africa. This annexure is naturally written from the perspective of NETCARE, replete with emotive language and contextualisations aimed at legitimising the stakeholder's perspective.

The annexure, entitled *Regulatory Regime: Impact on competition and costs* begins with a quotation from Edmund Burke, regarded by most as the father of modern conservatism and one of the earliest and most vociferous proponents for market forces. This introduction provides a clear indication that NETCARE's approach to the inquiry process, and participation in the healthcare sector, is motivated by free-market principles.

NETCARE argues that the South African environment is characterised by inappropriate regulations, which drive costs. In support of this argument they make extensive reference to an Organisation for Economic Cooperation and Development (OECD) report written by Ratio, a Swedish research group which is primarily funded by the Swedish Free Enterprise Foundation.

There are a number of problems with this report, and the way in which they use it to support their argument. Firstly, the OECD report aims to investigate the effect of regulations on 'companies' in the most general sense, across various markets. The report is not in any way focussed on the healthcare sector specifically. Secondly, in using the content of this report, NETCARE makes use of selective quotation, thereby explicitly omitting relevant sections that relate to the unique regulatory requirements in the healthcare sector. If they had not quoted selectively, the following would have been included:

"Ultimately, public intervention can be justified in order to ensure that goods or services with large positive externalities are provided, such as education, basic research and healthcare."

p. 8

Further to this, the OECD report continues to outline the three principles of political economy that provide motivations for regulatory interventions. These three principles are in direct support of the National Department of Health submission. Firstly, to provide public goods. Secondly, to ensure that merit goods, including some forms of healthcare, are provided to a greater extent than would otherwise be the case. These first two are necessary in order to ensure economic efficiency. Thirdly, and crucially, to create a fairer distribution of resources in society. As outlined in the National Department of Health Submission, this third principle speaks to a normative notion of equity.

NETCARE ultimately recommends the "trimming back [of] the inefficient regulatory morass which distorts competition in the private healthcare sector" (p. 13). While NDoH supports the idea of always striving towards a coherent legislative, regulatory and policy context, the review of any legislative context must take into consideration the market failures that characterise the healthcare sector.

The opposing views on the same regulatory arrangement show that the interpretation of impact on competition depends on the vested interest of the stakeholder. An example is the Designed Service Provider (DSP) arrangement which allows medical schemes to select providers and contract with them. The NHN (*Section 5, Point 105*) considers DSP arrangement anticompetitive. Mediclinic Southern Africa claims that "Hospital and doctor networks have become powerful tools for medical schemes to channel their members to preferred providers. This forces private hospitals to accept medical schemes tariffs" (*Page 24, Point 2.5.2.7.9*). The same regulation – DSP – is presented by medical schemes as the main tool which they can use to manage supply of services and their costs thereby increasing access to quality health services to beneficiaries. The international experience shows that supply side regulation improves effectiveness of healthcare services and does not limit the demand for health services compared to demand side regulations (e.g. user fees).

Another example is the concern of private hospitals and hospital networks about the regulatory framework of medical schemes (open enrolment and community rating). Netcare claims that "The enforcement of open enrolment and community rating by the Medical Schemes Act has driven up costs" (*p. 25, Point 43.1 + 43.2*), as well as Mediclinic ("MSA open enrolment and community rating enforcement has driven up utilisation and therefore costs", *p. 18, Point 2.4.6.7.3*), Life Healthcare Group ("Government introduced open enrolment and community rating without any of the reforms critical to ensuring sustainability including risk equalisation, mandatory cover and risk based solvency. This results in both anti-selection and increased utilisation, with a significant portion of the annual increases experienced by medical scheme members being driven by utilisation rather than price." *p. 7, Point 1.2.2*).

In this point hospital groups **do** not reflect the benefits of these regulations for patients, especially for sick patient who can afford the medical insurance thus benefiting greatly from these regulations. Open enrolment and community rating is inherent part of any health system that achieved universal health coverage and therefore NDoH supports these principles. The open enrolment is one of the main tools how to achieve competition among medical schemes and thus any changes in these regulations could significantly alter the functioning of the private healthcare market.

The submissions of hospitals and hospital groups are misleading from the main causes of costs drivers pointing to other stakeholders (government, medical schemes, HPCSA). In their assessment of drivers of expenditures they point to utilization as the main driver (e.g. Mediclinic – “Increasing demand and utilisation is the reason for increase in expenditure and turnover, not an increase in cost”, p. 17, *Point 2.4.6.6.*). They do not reflect on the fact of supplier induced demand which can be shown on the percentage of C-sections in the private sector or higher intensity of care. Even the background documents financed by the industry (Econex: Medical Scheme Expenditure on Private Hospitals, Occasional Note, August 2012) agree that the longer stay in hospitals might be caused by supplier-induced demand.

They do not reflect the preferences and interests of the patients and the South Africans in general, thus prioritizing own interests and profits over the benefits of patients. Their argumentation cannot be considered unbiased and reliable as they are in conflict of interests and may present only information which fits their vested interest. Therefore any evidence based on own data and methodology which is not open for scrutiny should be considered void and should be disregarded. Inquiry Panel should investigate the main concerns and issues raised and build own methodology and let the public scrutinize it. Only such robust research can provide any relevant information for the decision of the Inquiry Panel. An example is the supporting analysis commissioned to Econex company (*NETCARE annexures – H1-10*) which present some findings (*Econex: The South African Private Healthcare Sector: Role and Contribution to the Economy, Research note 23*) which are based on theoretical model and thus do not have real evidence.

In conclusion, the submissions from various hospital (and other provider) groups must be viewed in light of their for-profit motivation. Although being for-profit does not preclude an organisation from being efficient in attaining outcomes other than profit maximisation, it does mean that the other outcomes are usually of interest insofar as they assist in furthering profit-related gains.

The outcomes of interest, as outlined in the National Department of Health submission, are:

i. Right to access health care

The Department must ensure access to health care as enshrined in the Bill of Rights, Section 27 of the Constitution:

"Everyone has the right to have access to health care services including reproductive health care...

The State must take reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights.

No one shall be refused emergency medical treatment".

ii. Social solidarity

The health system must provide financial risk pooling to enable cross-subsidisation between the young and old, affluent and impoverished as well as the healthy and the sick.

iii. Equity

The health must be structured in manner that ensures a fair and just health system for all and that those with the greatest need will be provided with timely access to health services.

iv. Health care as a Public Good

Health care shall not be treated like any other commodity of trade, but as a social service.

v. Affordability

Health services must be procured at reasonable cost that recognises the need for sustainability within the context of the country's economic resources.

vi. Efficiency

Health care resources will be rendered and utilised in a manner that optimizes value for money.

vii. Effectiveness

It is the degree to which an intervention results in expected outcomes in every day settings. The health system (public and private) must meet acceptable standards of quality and proactively contribute towards positive health outcomes.

viii. Appropriateness

The health system must support innovative service delivery models that are tailored to local needs while recognising the diversity of population needs and the interests of various stakeholders involved in the provision and delivery health services.

The Department is committed to addressing any regulatory fragmentation or contradictions in a systematic manner, with the aim of reducing unnecessary bureaucracy and finding efficient policy levers to attain the outcomes of interest. Additionally, the Department is committed to working with other government departments to improve policy coordination and implementation particularly in dealing with the social determinants of health.

ii. Issues relating to pricing and reimbursement

a. Price regulation for pharmaceutical products

Mediclinic South Africa and NETCARE argue that the significant difference between the prices for pharmaceutical products in the public as compared to the private sector indicates that there is cross-subsidisation from private to public. Thus, they argue, measuring costs and expenditure in the private sector is skewed by the 'subsidies' to state (p. 29, Point 2.6.4.7). Furthermore, the public sector also subsidises the private sector under circumstances where his/her medical scheme benefits expire and the member is then pushed onto the public sector for health services.

The Department of Health argues that the two-tiered system leads to two almost completely separate markets, thus undermining the cross-subsidisation argument. Pharmaceutical companies choose where to focus their products and many companies that focus on the private sector also participate in the public tenders in order to gain income from the 'additional' market. That is, the argument of cross-subsidisation is unfounded, and so long as the prices achieved in the public sector are above marginal cost it is worth competing, particularly in light of the large volumes. This is in line with the standard principles of differential pricing (Danzon 2003). Many companies also leverage the volume of state tenders to achieve lower production costs.

The Department does, however, concur with the claim that there is room for further efficiency gains within the private market. The regulations relating to International Benchmarking, logistics fees, the annual Single Exit Price adjustments and the pharmacoeconomic evaluations are all aimed ensuring that the South African private market achieves globally competitive prices.

b. Price regulation for surgical supplies

The Department aims to implement price regulation for surgical supplies in a gradual fashion. It is acknowledged that pricing in this sector is currently irrational and that competition is not always based on quality.

c. Price regulation for services

The National Hospital Network submission makes reference to the United Kingdom Competition Commission into the private healthcare system, where the Commission ruled against price controls. Their argument implies that the UK Commission found no *need* for price regulation.

This is, however, misleading. As outlined in the National Department of Health submission, the UK Commission found that there were a number of features in the private hospital market which, together, gave rise to adverse effects on competition, leading to higher prices being charged for inpatient care (p 12, point 7). The Commission's decision not to recommend price controls is supported by the following statement: "We thought that while price control may be effective in reducing prices, it would be unlikely to encourage competition on quality or range in the market" (p 302, footnote 84, reiterated on p 441, section 12.63). Further, although price regulation would be effective in addressing the symptom, the Commission recommended that the cause of the problem be addressed through various measures, including divestiture and means to encourage competition through publishing performance data based on "objective quality criteria" (p 448, 13.4).

In the current South African market competition based on true quality (vs. quasi-quality in hospital services etc.) is unrealistic, due to the lack of comparable data on quality indicators and health outcomes. This means that in our current context, price controls are necessary in order to deal with the structural inefficiencies of the private hospital market. It is recommended that appropriate health system reforms are introduced to also enable improved monitoring of quality, with the aim of also increasing competition based on published performance data, and strategic purchasing. This is supported by the Mediclinic submission, which calls for the routine collection and publishing of reliable data on utilisation and quality (p 29, Point 2.6.4.2). The Department would argue, however, that the scope of this body should include regulatory oversight and stewardship of the private hospital sector.

NETCARE argues that price regulation for private hospital services should not be considered in South Africa, arguing that price regulation is only suitable in monopoly industries (p 63, point 120-121). The Department is of the opinion that the current market context does warrant price regulation, for reasons relating to both economic efficiency, and normative equity concerns. Even though many of the private hospitals will readily argue that the Competition Acts promotes competition and curbs oligopolistic behaviour, evidence is available that indicates to the fact that the private hospital market is actually highly

concentrated in nature with the three main groups (NETCARE, Life and Mediclinic) owning in excess of 80% of market share.

Internationally, the last two decades have seen substantial focus on driving further competition in the delivery of health and hospital services. On the demand side, governments have sought to improve the availability of information about the performance of health care services and providers and support more informed choices by patients. At the same time, governments have undertaken reforms seeking to restructure supply and financing arrangements to encourage competition – even in health systems with long standing traditions of publicly operated health care services.

The scope of regulatory interventions on the part of Governments also varies greatly, from highly regulated private markets in the Netherlands to relatively weak regulatory oversight in other contexts, especially those that have greater reliance on market forces. However, in countries such as the United States of America, Government has taken deliberate efforts to regulate the market in a manner that prevents the emergence of market concentration among a few provider groups. While many government interventions focus on the supply-side factors e.g. hospital bed capacity and number of private hospitals in operation, many efforts are increasingly focusing on consumers, users and patients. This is by trying to entrench within the regulatory framework an obligation on the part of regulators, service providers and even insurers/payers to provide clear and easily understood information to empower them about the performance of private hospitals regarding key quality indicators.

iii. Hospital licensing and Certificate of Need

All submissions made by hospital groups outlined areas of concern relating to a) hospital licensing and b) certificate of need.

The Department accepts that due to historical arrangements the licensing of private hospitals is currently characterised by a fragmented approach and processes that need to be better streamlined and strengthened. It is proposed that this function be centralised to ensure improved coordination and standardisation across the provinces. The improved licensing process should also incorporate meaningful penalties for poor quality outcomes. Additionally, it is proposed that the licensing criteria be reviewed to incorporate appropriate aspects relating to the Office of Health Standards and Compliance, as well as the Certificate of Need.

The National Hospital Network claims that current regulations (it is not clear which) prohibit "telemedicine and other innovations, which in turn limits access in regions with little resources" (point 89.4). This rather vague claim is factually incorrect because the State actually supports the roll-out of telemedicine and related innovations as part of expanding access to quality health care. The only requirement that may be considered restrictive here is in relation to innovations that may have radiological implications because then such equipment will have to be registered for necessary reasons, particularly patient safety.

Life Health Care Group presented the view that:

"Licensing regulations are inappropriate as the state should not be involved in determining the need for a private hospital, as this is tantamount to regulating

competition. The establishment of private hospitals should be determined by market forces which are better placed to regulate need in the private sector." p.64

The Department has already argued that due to the nature of the healthcare market, it is necessary for the state to be involved in the regulatory process. It is clear that market forces, particularly in light of historical and pervasive inequality, are not best place to determine how and where private hospital markets take shape, and what variables hospitals compete on.

Epidemiologically, South Africa is faced with a quadruple burden of disease as a result of HIV and AIDS and Tuberculosis; high maternal neonatal and child morbidity and mortality; rising disease burden of non-communicable disease; and high levels of violence and trauma. South Africa has an HIV prevalence of 17%, and the estimated number of people living with HIV and AIDS is 5.26 million. With respect to maternal, newborn and child health, the burden of disease is 2-3 times greater than the average of comparable countries and about 1% of the global burden. Evidence indicates that South Africa accounts for 1.3% of the global burden of injuries. Although non-communicable diseases account for less than 1% of the global burden, the South African rates are two to three times greater than the average for developing countries.

The changing population and health profiles in South Africa occur within financial resource constraints and in an environment in which there is mal-distribution of the health workforce. Work undertaken by the Department of health has demonstrated that despite having relatively higher numbers of health care professionals, there is mismatch of human resources in the public and private health sectors relative to the size of the population served; and in urban and rural areas; as well as inefficiencies in the use of the available human resources. This mismatch has contributed to the very poor health outcomes of South Africans, particularly for the lowest income populations and households. As a consequence of this, the health system's performance continues to be well below that of countries of similar socio-economic development.

For the Department, an important policy intervention is to ensure that the quantities, qualities and skill mix of the health workforce match the current and future needs and expectations of the population. Government's role is to promote the principles of justice, solidarity and social inclusion to ensure health system coherence and responsiveness to the health needs and expectations of the population, taking into account the demographic, epidemiological and socioeconomic circumstances of that population. Section 27 of the Constitution articulates that the State has a constitutional obligation to ensure that everyone has access to health care services. In this regard, the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

The obligation to *'take reasonable legislative measures'* resulted amongst other legislation, in the National Health Act 61 of 2003 and the development of regulations to effect the National Health Act. Government is a key player in framing and governing regulatory mechanisms and to execute its duties requires strengthening of regulatory mechanisms through amongst other policy instruments: ensuring training and production, maintaining quality and management of health care professionals and providers and ensuring that access and equity are not compromised.

Policy levers to address human resource challenges should therefore include regulations to ensure access, equity and quality through accreditation standards and norms; and ensuring equitable distribution of practitioners and providers through licensing and certification. The government is implementing this through an independent Office of Health Standards Compliance (OHSC) and the Certificate of Need (CoN). Whilst government's primary role should be to represent public interest, cognisance should be given to the dimension that corporate and financial interests of health care providers including their representatives such as professional associations and /or the private sector can be in contradiction to the role government should be playing. It is in this instance that government should be able to adopt regulatory measures to promote the public health goal that is in line with Constitutional obligations.

iv. Claims regarding the cost of public vs. private hospital admission

Mediclinic devotes a section of their submission to outlining the findings of Ramjee (2013), in research commissioned by the Hospital Association of South Africa, entitled *Comparing the cost of delivering hospital services across the public and private sectors in South Africa*.

The National Department of Health has a number of concerns about the methodology (as well as the independence) of the report. The calculation is flawed in the basic definition of hospital, admission and type of services provided. It includes all hospitals in the public sector including psychiatric, TB and rehabilitation hospitals that do not exist in the private sector. It bases its estimate of public costs on Patient Day Equivalent (PDE)¹ – a mix of admissions, out-patient care and emergency admissions. Lastly, it bases the costs of PDEs from district hospitals that have different structure of patients and skills compared to private hospitals.

The author applied arbitrary coefficients which further bias the results. To adjust for structural differences in underlying cost base the author used coefficients on aggregated level which do not allow adjustment for case mix differences, differences between the populations accessing the services and the content of services (e.g. pharmaceuticals used, frequency of tests done, organization of service). Use of slightly different values could significantly change the results.

In summary, average cost per admission can only be compared when the same health problems are compared for similar patient groups admitted at similar types of hospital (e.g. Cesarean section, hip replacement). Comparison on aggregate level is flawed and cannot provide relevant information to compare the public and private sector hospitals.

In arguing that the costs of public and private hospitals are comparable, Mediclinic and other hospital groups argue that if private hospitals were rated for Value Added Tax (VAT) the price of healthcare would reduce significantly. This notion is rejected by the Department on the basis that there is no guarantee that in the context of for-profit interests, any VAT exemptions will translate directly into cost reductions that are passed on to the population.

¹ This indicator measures how the resources available to the hospital are being spent and is a marker of the efficiency of the hospital as a whole. It is a composite process indicator in that it links financial data with service-related data from the hospital admissions and outpatients.

Similarly, NETCARE argues that they are not earning 'excessive profits' (p 37), but rather that profits are reasonable when compared with international experiences, as well as in comparing public and private cost structures. In addition to being mindful of the limitations of international data comparisons, the Department would like to encourage the Inquiry Panel to review 'profit' and input costs in the context of productivity measures, where productivity is reviewed in light of health outcomes achieved relative to input costs.

v. Issues relating to hiring of healthcare professionals, including:

a. Issues relating to the South African Nursing Council

The National Hospital Network argues that the regulatory context overseen by the South African Nursing Council is a significant cost driver for private hospitals. This view is supported by NETCARE, Life Health Care Group and Mediclinic South Africa (p184).

Specific aspects of concern relate to the closing of nursing colleges, shortages of nursing staff and pay scales in the public sector.

The Department's strategic shift from hospi-centric service delivery to a re-engineered Primary Health Care (PHC) approach requires changes in the training, recruitment and distribution of human resources in health care in South Africa. This requires that PHC becomes the primary mode of health care delivery focusing on health promotion, community outreach, rehabilitation and prevention of disease. Therefore all activities in the human resource development chain should be aligned with this strategic vision.

In this respect, the National Strategy for Human Resources in Health (HRH) was developed in 2011 to inform the process of implementing change in HRH. The Strategy is implemented through activities undertaken by provincial Departments of Health, Faculties of Health Sciences, the professional associations, labour organisations, Statutory Councils, health care managers, professionals, health care workers etc. The process of planning improvements in HRH is guided by the National Department of Health's 10 Point Plan which incorporates human resources planning, development and management as one of the priorities (includes for example Re-opening of nursing schools and colleges). Strengthening the health service training platforms (Academic Health Complexes, Nursing Colleges, Ambulance Colleges) is a priority for the HRH SA Strategy. It includes also the strengthening Academic Health Complexes and nursing colleges to strategically manage both health care and academic resources and provide an integrated platform for service, clinical, research and education functions, among other activities.

In order to ensure that the training platform remains relevant to meet the needs of the population and supports future health systems reform, the Department must retain its position as the core training platform for nursing in the country. However, it is agreed that better partnerships and involvement of public private interactions must be considered more strategically as part of the broader programme of health system strengthening and capacity building. Under such an arrangement, government will have to ensure there is adequately regulated oversight for the private sector in relation to training of nurses and the skills set that they graduate with.

b. Issues relating to the Health Professions Act and regulations including the hiring and training of doctors.

Restrictions on the employment of healthcare professionals is cited as a barrier to innovative service delivery mechanisms by all the main hospital group submissions.

The Department has not been presented with any evidence that potential efficiency gains resulting from employing healthcare professionals will be passed on to the patients. It is argued that the for-profit motive of the hospitals and professionals will simply result in absorption of any savings.

There is, however, support from National Department of Health for innovative contracting mechanisms between suppliers and medical schemes that serve to place some shared financial risk across the hospital and healthcare professional, particularly for specialist services. Many of the stakeholders submissions express frustration that private providers are not permitted to train healthcare professionals, in spite of there being a chronic shortage of certain skill sets in South Africa.

The Department recognises the many challenges that exist within the Human Resources for Health realm, not just in relation to the training and recruitment of doctors but the entire spectrum of health professionals required to deal with the population's epidemiological needs. This is why as early as October 2011, the Department published the Human Resources for Health Strategy document as a guide to action with the immediate effect of having to undertake a range of activities, make new policies, develop new programmes, make detailed staffing plans for new service strategies, and manage our health care workforce in ways that motivate them to provide quality health care.

The Department is committed to consultative engagement and to work together to build the human resource capacity and working environment to ensure quality health care. Most important health professionals and cadres must know that we value and need them. Without their skills, knowledge and caring attitude we cannot build the re-engineered health care system we are striving for. The strategy framework outlines the following priorities, which are intended to deal with matters pertaining to both policy and regulatory capacity:

- i. Leadership, governance and accountability
- ii. Health workforce information and health workforce planning
- iii. Reengineering of the workforce to meet service needs
- iv. To upscale and revitalise education, training and research
- v. Create the infrastructure for workforce and service development - Academic Health Complexes and nursing colleges
- vi. Strengthen and professionalise the management of HR and prioritise health workforce needs
- vii. Ensure professional quality care through oversight, regulation and continuing professional development
- viii. Improve access to health professionals and health care in rural and remote areas.

These 8 priorities are intended to ensure that the right quantity and quality of health professionals (doctors, nurses, specialists, allied health professionals, etc) are available in the country to address the health needs of the population:

c. Issues relating to the hiring of foreign national healthcare professionals

Submissions by New Hospital Network, NETCARE, Mediclinic, and Life Health Care Group also express frustration at the difficulty faced in hiring foreign national healthcare professionals.

The Department notes that health professionals are highly skilled and, like other skilled professionals, very mobile. The migration of foreign health professionals in and out of South Africa needs to be managed. As indicated in the Human Resources for Health strategy document (section 3.1.12, p 32): *“an instrument for managing the supply of the health workforce is the management of the recruitment of foreign trained health professionals. Current national NDoH policy is to limit recruitment of foreign doctors to a maximum of 6% of the medical workforce and only to use country-to-country agreements. There are currently 3,004 foreign doctors in South Africa (approximately 10% of the medical workforce)”*.

Priority has been given to recruitment of Cuban doctors for South Africa and training of medical students in Cuba, based on a bilateral government-to-government agreement. Bilateral agreements are also in place with Iran, Tunisia, Germany and the United Kingdom. The main international policy framework for addressing shortages and maldistribution of health professionals is the Global Code of Practice on the International Recruitment of Health Personnel which Department ascribes to.

Additionally, efforts have been put into place to review the foreign recruitment policy process and to address this matter proactively through a number of interrelated activities such as:

- i. Reviewing the foreign recruitment policy on who may work in South Africa and under what arrangements
- ii. Review all applications with the Foreign Workforce Management Programme
- iii. Refrain from recruiting from developing nations which have a shortage of health professionals
- iv. Actively recruit South African health professionals ‘back home’ (doctors nurses, pharmacists and other categories including non-health professionals working in the health sector such as health economists and data analysts)
- v. Ensure a better coordinating mechanism between the Departments of Health and Home Affairs and the Health Professions Council of South Africa (HPCSA) for recruitment of foreign health professionals
- vi. Implement an effective recruitment and management process for foreign health professionals
- vii. Improve as needed the international linkages for training in South Africa and abroad

vi. Role of competition law and policy, terms of reference for the Inquiry

NETCARE argues that the Inquiry process should be conducted in terms of traditional competition law principles and that it should not be concerned with industrial or health policy objectives, nor used as a vehicle for promoting policy initiatives (Point 118, p 68).

The Department strongly opposes this narrow interpretation of the role of the Competition Commission inquiry. Rather, the *Health Market Inquiry* is an appropriate mechanism with which to glean the relevant facts required to make evidence-based recommendations within the context of the constitutional right to healthcare. As such, the inquiry should adopt a

rights-based, health as a public good, societal perspective, rather than a narrow commercial one.

vii. General methodological concerns

There have been a number of references to methodological concerns outlined throughout. These concerns relate to non-disclosure of funding and conflicts of interest of authors, as well as the lack of peer reviewed references. Submissions by Life Health Care Group, Mediclinic South Africa, NETCARE and National Hospital Networks all make reference to the findings of research from Econex.

Although the Econex research is presented to be independent and balanced, there is no declaration of funding or conflicts of interest, as is good practice with independent research. Additionally, the notes are published directly from Econex, with no indication of peer review. It is common knowledge that the research presented by Econex is industry funded, and closely tied to the HealthMan provider lobby group. The inquiry panel is, therefore, advised to apply due caution in interpreting the findings presented in any of the Econex papers.

b) SPECIALIST GROUP SUBMISSIONS

In this section, the National Department of Health provides responses to the specific areas raised by South African Private Practitioners Forum (SAPPF), South African Medical association (SAMA), South African Dental Association (SADA), Radiological Society of South Africa (RSSA) and the South African Society of Anaesthesiologists (SASA) in their submissions. These can be summarised as:

1. Understanding of the mandate of the Department of Health and principles social solidarity and equity;
2. Issues relating to coding, pricing and billing/reimbursement;
3. Issues relating to a 'fair' earning and cost recovery for capital; and
4. Cost inflation.

i. Understanding of the mandate of the Department of Health and principles social solidarity and equity

The submission made by SAPPF argues that the current two-tiered system should continue to exist, and that the private sector plays an important role in alleviating the burden that would be faced by the public system. Additionally, it is argued that the only 'cost' to state relating to the existence of the private sector in its current form is in the form of the tax credit allowed as an offset against medical scheme member contributions.

This logic completely misses the rationale for change in the current South African health system, as motivated for in the National Development Plan, the National Health Act and the Constitution of South Africa. While some perceive the Department of Health as the Department of *public* health, and, likewise, the Minister as the Minister of *public* health, this is patently not the case. As such, it is the Minister's responsibility to steer South Africa towards a system that is not characterised by inefficiencies, inequality, inequity and fragmentation but rather a unified health system.

In a similar fashion, SAPPF describes the principle of social solidarity as "essentially just a principle prohibiting discrimination based on risk factors" (pp 8-9). This definition of social solidarity principles is not only factually incorrect, it highlights the extent to which the SAPPF representatives are removed from the reality of the South African context, and the Constitutional mandates that govern all of us.

The World Health Organisation provides a clear overview of the kinds of redistributive measures that are included in the term 'Solidarity'. Specifically, these include both the young and healthy supporting the old and ill, and the rich supporting the poor. Thus, social solidarity includes both income and risk cross-subsidisation, not only community rating for the provision of prescribed minimum benefits.ⁱ

ii. Issues relating to coding, pricing and billing services

a. Coding of services and billing

SAMA proposes that the Doctors' Billing Manual (DBM), rebranded as the Medical Doctors' Coding Manual, should serve as the industry standard for coding. SAPPF argues that a non-profit, independent organisation should be responsible for developing industry codes, but indicates that the South African Classification of Healthcare Interventions would be suitable for this task. SACHI happens to be closely linked to HealthMan, a consultancy group known to push the professional and commercial interests of specialist provider groups. SASA argues that the coding responsibilities should rest with the relevant professions, as does RSSA.

In motivating for control over the coding of services, these submissions all go to great lengths to distinguish between the 'technical' task of establishing a schedule or coding structure for healthcare activities, and the 'political' task of assigning values and payment levels to these activities.

As such the SAMA DBM is described, innocuously, as a tool aimed at improving communication and reporting through uniform language between clinicians and medical schemes, and that this uniform language serves to improve efficiencies and reduce confusion. (p 10, Section 3). The DBM has, however, always been a billing manual with associated tariffs. It still contains tariffs for RAF and COIDA. Additionally, it contains billing rules and guidelines that can influence providers to use higher value codes when billing. The DBM was developed by SAMA, primarily for SAMA members. Its function is inextricably linked to the process of billing and income generation from third-party payers.

Another challenge with the DBM is the Relative Value Units (RVUs). SAMA claims that the RVUs are based on a resource-based relative value scale developed by Harvard University (p 15). These RVUs were developed in the 1970s and SAMA has not undertaken the necessary time and motion studies to support the applicability of the RVUs to the South African context.

It is the Department's position that the process of creating codes should be separated from the process of assigning values. However, it is naive to think that the manner in which codes are structured is a neutral process, or that this process could be managed by the clinician groups without the risk of perverse incentives influencing the outcomes.

As argued in the National Department of Health's main submission, the manner in which the codes are organised creates perverse incentives for doctor billing behaviour in order to maximise profit. As such, the activity of standardising a coding structure for South Africa must be conducted with clear regulatory oversight from the National Department of Health. The Department's position on this matter is that there must be efforts directed at creating an entity to be responsible for setting and oversight of health services coding (ICD and procedural) practices.

b. Pricing of services

The specialist groups appear to be generally in favour of establishing a national reference price list, or embarking on collective negotiations. RSSA argues that the previous process for determining guideline prices or tariffs was a "useful and workable system" (point 8.1).

Rather than entering into a blame game regarding the National Health Reference Price List process, it would be wise if the parties could begin to look for a way forward that will not repeat the mistakes made on both sides. The Department of Health will work with the Inquiry Panel in order to arrive at a best way forward for pricing of services, taking into account lessons learnt locally as well as international experiences.

The NDOH preference is to establish a National Pricing Commission as the most rational and appropriate solution to strategically and conclusively deal with the current health tariffs lacuna in the private sector (unless Ministerial position on this matter has changed). Many countries across the world have some form of health tariffs negotiation and setting process. This is evident from the recently published paper by OECD in May 2014 titled "*Pricing and competition in specialist medical services – An overview for South Africa.*" The paper indicates that in most OECD countries the public sector tends to have some form of price setting for specialist medical services; this is used to purchase services from the private sector and can provide benchmarks for private insurers.

iii. Issues relating to a 'fair' earning and cost recovery for capital

The submission by SASA (pg 3) states that "Income earned must be sufficient to encourage new entrants into the market and keep the services available and thus have access." A 'fair' earning can only be considered in relation to information about true cost structures, which is currently lacking.

SAPPF argues that pricing should incorporate item costs (including labour costs) as well as a factor for 'return on investment'. This methodology is technically flawed, as it is standard practice to account for capital investment through considering the price of the equipment, the depreciation and the expected use, rather than a standard inflationary 'return on investment', which implies a flawed rent-seeking structure.

RSSA and SADA argue that the high capital costs associated with both radiology and dentistry are driving costs, particularly in the context of a weak rand. The Department would like to recommend that the Inquiry Panel review information about the high costs of capital equipment, particularly for radiology, in light of the following:

1. Multiple branches based at more than one private hospital, often in close proximity lead to duplication of equipment and unnecessary duplication of costs
2. The ratio of 1 radiologists to 80 hospital beds in the private sector is high
3. A new private hospital with more than 100 beds and a radiology dependent surgical mix is not commissioned without an MRI scanner. There are currently 103 MRI scanners in the private sector and 18 in the public sector.

To address challenges in this area, the Department has started a process of looking into creating a Health Technology Assessment Unit/Entity to address the challenges identified in the health technology space. While this is clearly a long term initiative, it is important that clear criteria are put into place for the assessment of such technologies to ensure rational acquisition, fair distribution, patient safety and access as part of the broader programme directed at improving access to quality and affordable health services for the population.

iv. Cost inflation

SAPPF makes detailed reference to the 'Cost Disease' model of Baumol (Section 14.5). In his theory Baumol (1967)ⁱⁱ cited lagging medical sector productivity linked to the requirement for skilled human input as a reason for rising relative unit prices. In his model these rising unit prices together with inelastic demand account inevitable for increased spending. The rising cost of healthcare is deemed 'affordable' in the context of increased productivity and reduced costs in other sector.

Newhouse (1988)ⁱⁱⁱ, however, argued that although this explanation may apply in certain parts of healthcare, such as chronic long-term, lagging productivity did not seem plausible in a sector with so much technological change. Additionally, it is argued that spending on the areas in which lagging productivity might be plausible was not growing as a share of total spending, after accounting for demographics (Pauly 2011)^{iv}.

Apart from the various criticisms of the model, Baumol also indicates that the impact of the 'cost disease' disproportionately affects the poor. Even if increased productivity results in reduced prices in other sectors, providing more goods and services for less, the increasing costs of healthcare would serve as a barrier to entry for those who cannot afford them. This is particularly important in the context of increasing income inequality. In order to address this, there is a requirement for price regulation, financial pooling and strategic purchasing arrangements that redistribute the increased expenditures on health.

The notion that health sector labour productivity is inherently stagnant claimed by Baumol also proves to be wrong as new information technology made it possible for stagnant activities to become progressive. In particular the new ICT, imaging techniques and modalities, laboratory tests and new pharmaceuticals and devices have all accelerated labour productivity growth. The main issue remains as how to measure productivity and the contribution of different parts of the treatment process to the outcome of healthcare - improved health status of the patient.

The Towers Watson report "2014 Global Medical Trends" that is referred to by Discovery Health, Medscheme as well as NETCARE is not based on relevant data of prices of hospital services internationally, presents misleading figures and uses incorrect terminology that cannot be considered as measuring and comparing inflation internationally. The report is

based on responses from 173 leading medical insurers operating in 58 countries thereby allowing them to reflect personal opinions and skewed views on the private industry from their perspective. The report does not publish the sampling method or the survey contents to the public. It is not clear what the terminology “global average medical trend rates by country” means. Someone can interpret this as inflation which is incorrect, as it might refer to the growth rate in health expenditure by medical insurers or growth rate of medical rates/fees paid by the medical insurers (some of which might be for-profit voluntary insurance, some of them private not-for-profits, some private mutuals, etc.). The report is misleading in qualifying these figures for “Global trends in healthcare inflation” (page 42 of the report) as this figures includes a price, utilisation and quality changes.

For international comparison, only data based on the exactly same definitions of products and their costs and total prices should be used. Any measures of growth rate of the private sector (ie. Private insurance) industry cannot represent “healthcare inflation” as it includes changes in the number of people insured, the volume of services consumed and the change in the tariffs. NDoH would therefore suggest that the Inquiry Panel used other sources to assess the international comparison of healthcare inflation as this report is not relevant.

c) FUNDER AND ADMINISTRATOR SUBMISSIONS

The Department of Health aims to respond to issues regarding funders in this section. These issues are highlighted by funders themselves, but also provider submissions. These can be summarised as:

1. Non-healthcare costs, administrative costs and managed care
2. Risk selection, adverse selection and mandatory membership

i. Non-health care costs, administrative costs, managed care

Various participants expressed concern about the role of administrators, brokers, managed care organisations and non-healthcare costs. These are all dealt with in principle in this section. The specific concerns raised relate to the efficiency of the various administrative arrangements and the risks of perverse incentives as a result of the for-profit motive associated with third-party administrators and brokers.

From an economic perspective, transaction costs, including administrative costs, are inevitable when making any kind of exchange, including the purchase and delivery of medical care. These costs should, however, be considered in light of expected utility gained from completing the transaction. In the case of healthcare, this means that the non-health care costs should be viewed in light of the extent to which they assist with the efficient attainment of health.

A literature review conducted by the WHO highlights this in saying 'administrative efficiency' depends on what is being achieved through administrative expenditure."In other words, 'high' or 'low' administrative expenditure should not be the focus, but rather the extent to which this administrative expenditure contributes to the efficient attainment of a specific goal.v

The Department recommends that 'non-health care costs' and the various definitions of costs associated with administration, managed care, brokers etc. should be carefully distinguished. Currently, although the distinction in function is clear in some instances, the distinction in terms of expected contribution to health outcomes is not.

The current legislative context is clear, and provides sufficient powers for monitoring all the actors involved in 'non healthcare expenditure'. There is not, however, sufficient oversight and reporting that focuses on the performance of these actors. A systematic reporting process should be in place to ensure that trustees monitoring the efficiency of the various actors in contributing towards the efficient attainment of health outcomes, and cost-containment. In the instance of brokers, monitoring should link payment to some measure of member satisfaction. Where schemes are self-administered, the same rules should apply regarding reporting. These performance measures should be available for review by CMS, and inform interventions where necessary.

A recent study published in Health Affairs shows that administrative costs account for 25% of total U.S. hospital spending, and concludes that this figure is a symptom of highly inefficient spending, largely driven by the system fragmentation (leading to duplication and inefficiencies).^{vi} The current fragmented and inefficient structure of the South African private

healthcare funding market, as well as the fragmented approach to procedures and codes must be addressed.

ii. Risk selection adverse selection and mandatory membership

Definitions from Folland, Goodman and Stano: ^{vii}

1. Adverse selection: A situation in which individuals are able to purchase insurance at rates that are below actuarially fair rates, often as a result of asymmetric information.
2. Risk selection: the enrolment choices made by health plans or enrollees on the basis of perceived risk relative to the premium to be paid.

Life Health Care Group, Mediclinic South Africa and Netcare argue that the principles of the Medical Schemes Act are to blame for cost increases. That is open-enrolment, community rating and prescribed minimum benefits in the context of voluntary membership and no risk-equalisation fund. These principles, it is argued, combined with inadequate gate-keeping mechanisms, result in adverse selection by members and unsustainable cost increases.

Discovery Health as well as Discovery Health Medical Scheme (DHMS) present data purporting to evidence "significant adverse selection trends" on the behalf of medical scheme members. These data include illustration of increases in chronic disease prevalence, increase in female members of child-bearing age, increase in claims for high-cost treatments within the first year of a member joining DHMS as well as evidence of members buying 'up' and 'down' according to their risk-profiles. They argue that member adverse selection is a significant contributing factor to contribution inflation, and overall expenditure inflation as the demand for high-cost services increases relative to the premiums being paid.

DHMS, Bestmed (Point 9.3) argue that schemes must be able to attract younger and healthier members into schemes through innovative branding, options, incentives to brokers etc. in order to keep the scheme affordable and sustainable. In this way, risk-selection, although prohibited, is approximated in open schemes through their ability to encourage young and healthy population groups to self-select into certain benefit options.

In the context of open and voluntary enrolment it is inevitable that individuals will execute choice in moving into, out of and between schemes or benefit options where possible in order to increase their overall utility. In the cases where members' schemes are chosen for them, through employment or through being a dependant, the ability/motivation to exercise this choice is reduced. It is also important to bear in mind that in the context of voluntary insurance where providers face high-powered financial incentives to oversupply it is difficult to ascertain whether member adverse selection or supplier induced demand (and even risk selection) are at fault.

Similarly, in the context of high-powered financial incentives, for-profit suppliers are likely to risk-select in order to maximize income, while not-for profit schemes are likely to risk-select in order to reduce costs.

There is no evidence that effectively differentiates between adverse selection by patients and the supplier induced demand by providers in the South African context. The evidence provided by DHMS is anecdotal and not systematic and thus cannot be viewed as representative of the market, nor to differentiate sufficiently between adverse selection by members, execution of informed patient choice, or supplier induced demand.

In order to prevent supplier induced demand, standard treatment guidelines and formularies should be implemented within the private sector, and the outcomes of services rendered should be publicly reported in order to monitor supplier quality and efficiency.

Communication regarding option design and coverage should be standardised in order to ensure that patients are able to execute informed choice when selecting a medical scheme or benefit plan.

Mandatory cover is recommended by all the participants who cite challenges with the current voluntary environment. Any change in favour of mandatory enrolment would completely restructure the nature of the private healthcare industry. Mandatory enrolment would require increased government regulation on the use of resources including auditing, price regulation, and control and compliance mechanisms as are applied in the public sector. It would also require sophisticated monitoring systems and an abundance of high-quality, standardised panel data.

Such changes would duplicate the efforts of the government to implement NHI and would duplicate the regulations and systems put into place as part of the NHI reform. Lessons from international experiences regarding mandatory contributions, pooling and risk-adjustments will be incorporated into planning for the National Health Insurance Fund.

3. CONCLUSION

There is an urgent need for national legislative frameworks to clearly identify the scope of competition as an instrument for promoting better health outcomes. Increasingly countries realise that adopting a “*hands free*” approach supported by market forces prices for health services is not a solution to promoting desirable competition within an environment that is intended to ensure access to a public good. Competition authorities and practitioners must have adequate capacity to undertake law enforcement to prevent market concentration and unfair market practices that hamper the enhancement of competition in markets.

More importantly, it implies that health policy must promote appropriate competition based on an appropriate set of variables, particularly that competition must be based on quality of care indicators. Many countries have taken deliberate measures to regulate the prices/tariffs levied for health and hospital services. The Department is obligated to ensure that patients and users of the health system have access to quality, accessible and fairly priced health services.

The National Department of Health, in collaboration with other government departments and statutory bodies, must implement proactive legislative and regulatory interventions to retain and strengthen oversight over the pricing and competition aspects of the health system. This role is in the form of providing information to patients through interactive mechanisms, not

just passive channels; effective anti-market concentration regulation; creating financial incentives for providers to operate optimally; and guaranteeing minimum quality and other related standards and norms that must be met by all providers, in both the public and private sectors as part of ensuring access to quality health services for the entire population. Mechanisms must be put into place to allow the government to routinely obtain data used by various stakeholders in the health system and must develop and implement systems to make this information more accessible for patients to aid their ability to make informed choices.

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- ⁱ <http://www.who.int/healthsystems/topics/financing/healthreport/SolidarityNo5FINAL.pdf>
- ⁱⁱ Baumol, W. J. (1967). Macroeconomics of unbalanced growth: The anatomy of urban crisis. *American Economic Review*, 57(3), 415_426.
- ⁱⁱⁱ Newhouse, J. P. (1988). Has the erosion of the medical marketplace ended? *Journal of Health Politics Policy and Law*, 13(2), 263_268.
- ^{iv} Pauly M.V, Mcguire T.G., Barros P.P. (2011) *Handbook of Health Economics*, Volume 2, Pages 1-1126, Cambridge, MA, USA
- ^v Administrative costs of health insurance schemes: exploring the reasons for their variability. Available at: http://www.who.int/health_financing/documents/dp_e_10_08-admin_cost_hi.pdf
- ^{vi} A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. *Health Affairs*. Sept 2014. 33:91586-1594
- ^{vii} folland p 611