APPENDIX 1 - RESPONSES IN RELATION TO SPECIFIC SUBMISSIONS

1.1 FEDHEALTH

1.1.1 Fedhealth's submissions contain a number of high level assertions. Unfortunately, Fedhealth has not included any meaningful factual basis for these assertions, nor has it included any empirical analysis. Many of these high level assertions (such as the bargaining position of medical schemes, the paper authored by Arrow, the assertion based on documents of the Council for Medical Schemes that there are "*super-normal*" profits) have been addressed elsewhere in these submissions or in Netcare's initial submissions and are, therefore, not addressed further under this specific heading.

1.1.2 There are, however, a few specific points which Netcare wishes to address directly.

1.1.3 It is worth noting that Fedhealth, like many of the other schemes appears to favour a non-competitive environment in which price competition between schemes and administrators is eliminated (see, for example, pages 4, 18 and 19 of the Fedhealth submissions). This is an unusual position to advance to a competition regulator. As set out in greater length in the paper by Ms Guerin-Calvert and Dr Davis, competition between medical schemes will result in the disciplining of medical schemes (and administrators) and ensure that consumers (being beneficiaries and members) benefit from the dynamism which arises from competition. The suggestion that competition in a market which is not growing (see pages 19 and 20 - which is an incorrect

premise, as set out below) simply results in "*churn*" and is, therefore, not beneficial is also not, as a matter of economics, a sustainable position to advance.

1.1.4 At various places in its submissions, including page 10, Fedhealth suggests that the market is "*stagnant*". This does not accord with the analysis which has been provided by Barry Childs in his report of October 2014. In its analysis, Fedhealth has adopted what the former chairperson of the Tribunal referred to as a "*solipsistic*" view of the world as it considers only open schemes and does not consider the significant growth in beneficiary numbers over the relevant period. Moreover, as indicated by Mr Childs in his report, GEMS absorbed a number of open scheme members, but open schemes were able to maintain membership numbers. In other words, schemes have managed to replace the lost GEMS members with other beneficiaries. This does not represent the stagnation alleged by Fedhealth.

1.1.5 It is noteworthy that Fedhealth stresses the fact that it is using a number of cost containment methods including the use of designated service providers, formularies and managed care initiatives (see page 16 of the Fedhealth submissions).

1.1.6 On the same page, Fedhealth raises a number of observations of "*interesting trends*". Unfortunately, these observations are not helpful as they do not provide any explanation or hypothesis for the "*trends*" which are reflected. Mr Childs' 2014 submission to the Commission sets out in considerable detail the likely reasons for increases in expenditure in relation

to private hospitals including the effect of benefit design (diminishing out of hospital benefits and members buying lower plans) and regulations (PMBs).

1.2 CAPEMED

1.2.1 As in the case of the other medical schemes, there are a number of high level points which have been raised by CapeMed which do not bear scrutiny. These have largely been addressed in other portions of these submissions and are not specifically repeated in these submissions.

1.2.2 One telling feature of the Cape Med submissions is the fact that a number of allegations are advanced without any factual or evidential basis being provided for the allegations, which makes it impossible for third parties to respond to the allegations. In this regard, the allegations under paragraph 9.48 are not supported by facts or any meaningful detail.

1.2.3 Netcare wishes to emphasise that the relationship between Netcare and the specialists which practise in its facilities has been set out in other portions of these submissions and it is submitted that Netcare has sought to ensure that its engagements with specialists and other providers (such as pathologists) do not give rise to any risk of providing incentives for over-servicing or under-servicing of patients.

1.2.4 Similarly, the "*case studies*" which are provided by Cape Med lack sufficient detail to enable parties to respond meaningfully to these studies. It should be noted that decisions relating to the treatment protocol of a specific patient would be taken by the treating doctor in consultation with the medical

scheme. The treatment of terminally ill patients is a matter of significant complexity. While Netcare does not support the provision of unnecessary or excessive treatment to terminally ill patients, decisions relating to the treatment of terminally ill patients are difficult for the patient, his or her family as well as the treating practitioner. These are, however, issues which should be dealt with by medical schemes through their managed care initiatives.

1.3 PROFMED

1.3.1 Profmed has also made a number of allegations which are not factually correct (such as the suggestion that there is stagnating membership of medical schemes – see paragraph 2.4). Its reflections on bargaining power have also been addressed in the paper by Dr Davies (see paragraphs 2.15, 2.16, 2.19 to 2.23, 6.3.6 to 6.3.7 and 8.1.1 to 8.1.7 of the Profmed submissions).

1.3.2 It is not clear as a matter of logic why the consolidation of schemes (paragraph 2.24 of the Profmed submissions) should be a source for concern. As indicated in the report by Mr Childs and by the Council for Medical Schemes itself, the consolidation of schemes does not give rise to any competition concerns. To the contrary, the consolidation of schemes may in fact act as a spur for greater competition between the schemes.

1.3.3 It is noteworthy that Profmed has highlighted the role played by schemes through managed care initiatives (see paragraphs 2.29 to 2.31 of the Profmed submissions). Increased competition between schemes and

administrators should provide a greater incentive for schemes to improve and amplify their managed care initiatives.

1.3.4 It is also curious that Profmed would suggest collective bargaining as being a means of enhancing competition between schemes (paragraph 6.3.14 of the Profmed submissions). Collective bargaining would largely eliminate price competition between schemes and would, therefore, as a matter of economic logic hinder competition as opposed to enhancing competition.

1.3.5 In paragraph 6.5.9 it is suggested by Profmed that the alternative reimbursement models do not involve "*risk sharing*". In 2014, Netcare estimates that approximately 41% - 45% of its revenue is derived from alternative reimbursement arrangements and that these did involve significant amounts of risk sharing. Alternative reimbursement arrangements range from relatively simple arrangements to very complex ones and it is not correct to make high level and unsubstantiated statements such as those made in this regard by Profmed.

1.3.6 At various places in its submissions, Profmed makes the unsubstantiated statement that the quality of nursing care has deteriorated over the past few years. It then suggests that this results in higher costs as the nursing staff are less competent (see paragraph 8.1.7). It is difficult to address such a statement as it does not contain any factual or empirical basis. Profmed does correctly, however, recognise there is a shortage of supply of nursing skills in the private sector and that this results in higher costs in procuring the services of nurses. Profmed then at various stages makes the

contradictory statement (for which no evidence is provided) that there has been a decrease in the quality of nursing but no concomitant reduction in pricing. As a matter of economic logic, this does not make any sense. If there is a shortage of nursing staff, this would result in higher costs of employment in order to obtain nursing services. An alleged decline in the quality of nursing skills in a world where nursing skills are in short supply would not change this fact.

1.3.7 In paragraph 9.2.7, it is suggested that hospitals make significant profits on the utilisation of technology and other medical devices. This is not the case in respect of Netcare which since 2008 has used net acquisition pricing for surgicals and other medical devices.

1.4 BESTMED

1.4.1 Most of the salient allegations by Bestmed have already been dealt with elsewhere in these submissions (such as the allegations relating to bargaining power of various medical schemes and issues relating to allegations of "*regional dominance*" by hospital groups).

1.4.2 In paragraph 112, Bestmed suggests that there is a reluctance on the part of open schemes to enforce DSPs, because this may place the open scheme in question at a competitive disadvantage. This statement does not take account of the fact that one of the largest open scheme options is Discovery's Key Care plan which, if it were to be considered to be an independent open scheme, would be one of the largest open schemes in the country.

1.5 **SAMED**

1.5.1 It is claimed by SAMED that its members are not involved in the final pricing of medical devices to consumers and that this is negotiated by hospitals and funders[1]. Given the fact that Netcare supplies medical devices on the basis of its net acquisition price, it is not clear on what basis this suggestion is made. In other words, the price at which the device is acquired from the manufacturer in question will be the price at which it will be supplied to the relevant patient. Netcare provides medical schemes with the opportunity to audit and investigate supplier invoices to confirm that the price at which the device has been supplied is indeed the net acquisition price.

1.6 **DISCOVERY**

1.6.1 In paragraph 59 of the Executive Summary of the Discovery Health submissions and paragraph 3.1.1.4 page 107, Discovery asserts that there is a "*lack of innovation*" in the hospital sector, alleging the lack of alternative delivery models and settings. Referring to other countries which have allegedly seen a "*rapid emergence of alternative care settings including specialised high volume centres, such as specialised eye hospitals or orthopaedic centres. Same day surgery centres…",* Discovery goes on to state that "*in the USA and Canada nearly 90% of elective procedures are performed as day surgery. In Scandinavian countries approximately 75% of all elective procedures are performed as day*

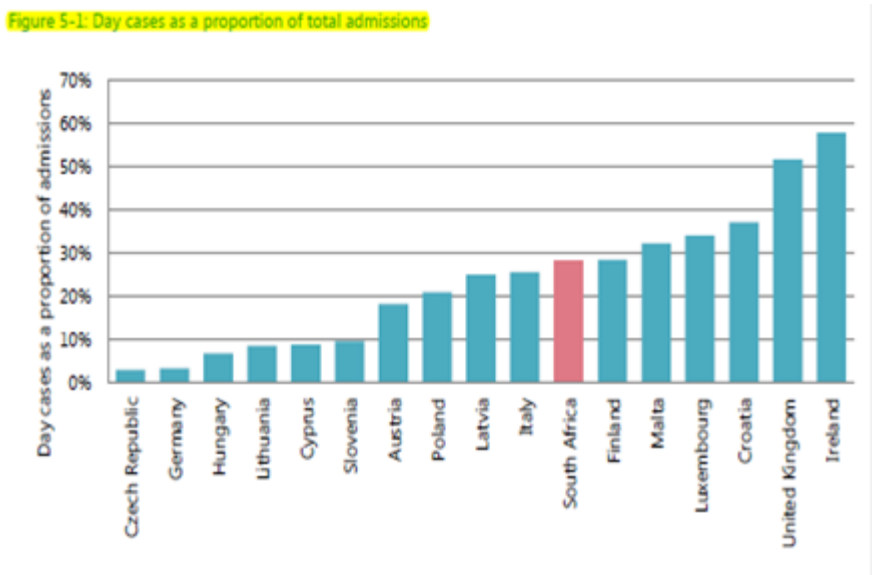
[1] SAMED submission, page 7, paragraph 21.6

surgery. It is estimated that only 15% of surgery in South Africa is conducted on a same day surgery basis".

1.6.2 This assertion is incorrect and is based on what appears to be an incorrect statement which was made in the Business day (entitled "Day hospital group to list on AltX" by Andile Makholwa, March 28 2014, 08:23).

1.6.3 The assertion that 15% of surgery is done in day hospitals in South Africa does not reflect the fact that a considerable amount of elective day surgery is performed in both acute and day hospital facilities.

1.6.4 In a paper by Barry Childs (International benchmarking of hospital utilisation), which is attached, contains the following statistics:

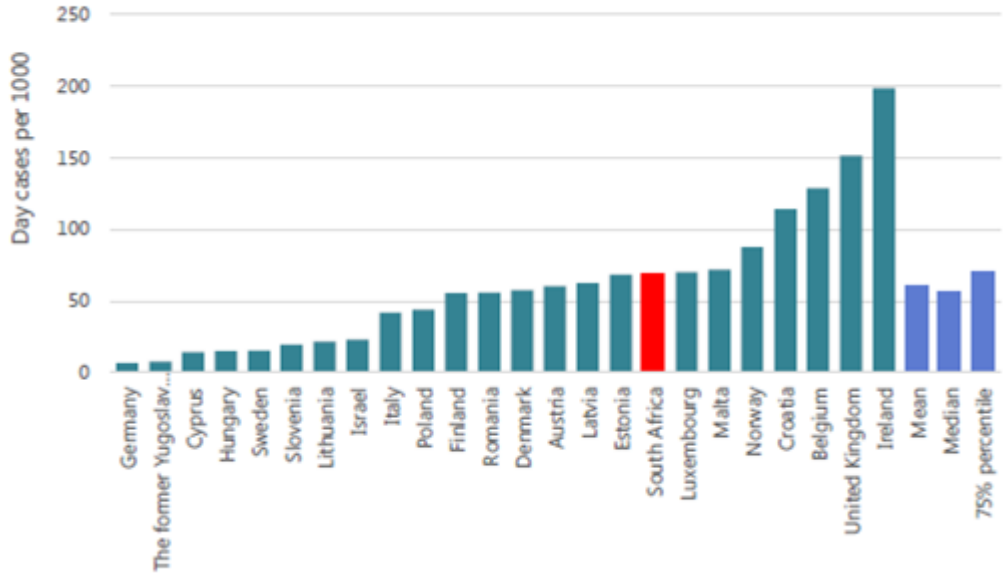


1.6.5 It is evident from this analysis that South Africa compares very favourably with other countries in relation to the number of cases which are performed on a day surgery basis. The graph reflects all admissions and, therefore, the proportion of elective surgery which is performed as day procedures

would be considerably higher (as this would exclude more intensive medical cases, maternity and trauma cases).

1.6.6 The figure below presents the variation in day cases per 1000 admissions across European Hospital Morbidity Database countries. Once again, it is clear that South Africa compares very favourably.

Figure 6-1: Variation in the day cases per 1000 across EHMD countries



1.6.7 Discovery Health recommends that doctors complete a summary of the hospital event which would improve the clinical coding, "*provide crucial information on the admission status, treatment and discharge diagnosis and status*". Discovery states that hospitals should be "*required to ensure compliance*" by the doctors.

1.6.8 The National Health Act does provide that doctors should provide a discharge summary to the patient.

1.6.9 However, it is impractical to suggest that hospitals should be responsible for ensuring compliance with this requirement. Doctors are not employees of the hospital, nor do they receive payment from the hospital for the services they provide to the patient, the medical scheme as the payer of the doctor's account is best placed to demand compliance in exchange for payment. Netcare, however, agrees with Discovery that ensuring compliance with these obligations would improve the quality of information which is available in the private sector.

1.7 MEDSCHEME

1.7.1 On page 27 of Medscheme's submissions, a comparison is performed which seeks to compare South African admission rates to that in other countries, using data from Medscheme and RGA insurance.

1.7.2 Medscheme does recognise that it is difficult to perform accurate comparisons of admission rates, but then seeks to draw the conclusion that the "differential" between the admission rates and length of stay in South Africa is indicative of a "systemic issue across the private healthcare market in South Africa".

1.7.3 However, the graph which is relied upon by Medscheme for the purposes of drawing these conclusions cannot bear such an interpretation.

1.7.4 Firstly, the source, richness and accuracy of the RGA data is not discussed in any detail which would be necessary if the panel were to be required to place any reliance on the data. Secondly, the countries which

have been selected for the purposes of the production of the graph are relatively arbitrary and the interpretation which is offered by Medscheme does not control for different market dynamics which may occur in the relevant countries. Thirdly, Medscheme fails to recognise the implications of a higher admission rate and lower length of stay, which could have done by showing the days per 1000 figure. Medscheme glosses too easily over the methodological differences evident in the way different countries approach data and admission definitions – one cannot simply say, 'we know there are definition issues, but we'll just ignore them and the problem is evident'. Medscheme's own data shows more about structural differences in the data (parallel by 2 other countries).

1.7.5 Moreover, a detailed report prepared by Barry Childs in 2014 (which has been attached to these submissions) indicates that these assertions by Medscheme are not correct.

1.7.6 On page 15 of its executive summary, Medscheme states that "Inappropriate behaviour may include the unwillingness of providers to provide details utilisation data, negotiate regionally …". This is repeated in several places in the Medscheme submissions.

1.7.7 It is not clear what is being referred to by Medscheme in this regard. Netcare certainly has not withheld this type of information from Medscheme. In fact, to the contrary, it populated the Medscheme database with the underlying fee for service data during the course of 2014. (The suggestion that Medscheme may not have detailed utilisation

data may arise from the fact that Medscheme and its predecessor managed care organisations, Solutio and Sanlam Health, pioneered Alternative Reimbursement Methods for hospital reimbursement. They successfully implemented per diem billing across most hospitals in 1997. Since this date they would have received billing information in Perdiem format and not the underlying fee for service information.)

1.7.8 In Part 3 of its submissions, Medscheme states that "the hospital provider groups are also unwilling to … negotiate regionally".

1.7.9 Netcare cannot recall any instance where Medscheme has requested that Netcare should negotiate tariffs on a regional basis.

1.7.10 There was one occasion where Medscheme requested special consideration in relation to a specific scheme which it represented which had a regionalised membership. However, the request was for a tariff on an "all-hospital" basis.

1.7.11 Nevertheless, Netcare made proposals to Medscheme in relation to this scheme with special rates at hospitals which were most suitable for the members of this scheme. However, the Netcare proposal was unsuccessful.

1.7.12 Moreover, Medscheme and certain of the schemes which it represents have implemented restricted hospital networks for certain scheme options – these networks include and exclude hospitals on a basis to grant the

designated hospitals regional exclusivity. This would appear to constitute regional contracting.

1.8 REFERENCE PRICE LISTS

1.8.1 There have been a number of statements made in submissions about the so-called RFP (or reference price list) process. Certain of these submissions do not properly reflect what actually occurred or properly reflect the complexities which arose during the course of that process2. As such, the following brief overview has been provided.

1.8.2 Following the end of the era of collective bargaining, the BHF continued publishing tariff schedules applying unilaterally determined increases. In 2004, the tariff schedule which was referred to as "the National Health Reference Price List ("**NHRPL**") which was published was simply an inflationary increase from the 2003 tariff. The Council for Medical Schemes published an NHRPL in 2005 and 2006 which was simply an inflationary increase from the 2004 tariffs which had been published and took no account of the significant changes in the reimbursement model which arose as a result of the regulation of pharmaceutical products.

1.8.3 On 21 December 2005, the CMS published Circular 69 of 2005 which invited submissions in respect of the 2007 NHRPL. Pursuant to Circular 69, a number of associations made submissions, including extensive costing studies, to the CMS, and a number of different practices within

[2] See, for example, pages 75 and following of the Department's submissions.

different disciplines were audited. The Department took over the RPL process during the course of 2006 and accepted responsibility for the publication of the NHRPL (in terms of section 90(1)(v) of the Health Act). To this end, the Department published draft schedules of the 2007 NHRPL for comment on 4 September 2006. This draft 2007 NHRPL was published on the Department's website and was accompanied by a document entitled "Executive Summary: NHRPL 2007 draft Schedules". According to the executive summary, comments on the draft 2007 NHRPL were to be submitted to the Department by 13 September 2006.

1.8.4 The Department subsequently issued a media statement dated 5 October 2006 which provided that the 2007 NHRPL would only be published after the finalisation of the relevant regulations under section 90(1)(u) of the Health Act and that draft regulations would be published for public comment (which was expected to last for three months) shortly thereafter. The media statement went on to state that the Department advised healthcare funders and provider groups "to use in the interim the [2006 NHRPL] and factor appropriate inflation index in determining the tariffs for 2007". At the time of the media statement, the Department thus envisaged that the 2007 NHRPL would only be published during the course of 2007.

1.8.5 After a threatened legal challenge by SAMA to the Minister's authority to publish the NHRPL in the absence of the enabling regulations being in place, the informal draft 2007 NHRPL was withdrawn from the Department website.

1.8.6 In an apparent attempt to fill the gap created by the fact that the Department did not publish a NHRPL for 2007, the CMS issued Circular 44 of 2006 to all medical schemes and administrators, stating that the latest available publication of the NHRPL was the 2006 version that was then on the CMS's website. The circular continued to state that the CMS's view was that "medical schemes, in the absence of an alternative, may consider having reference to the 2006 NHRPL in the definition of their benefits for 2007 (with appropriate modifications where deemed necessary), or alternatively apply appropriate inflators to their 2006 benefits". The circular then stated that the CMS had been informed by Statistics South Africa that the relevant CPIX adjustment was 4.9%.

1.8.7 Shortly before the end of 2006, the CMS published the "*National Health Reference Price List 2006 (with 4.9% inflator)*" on its website. This publication of an updated version of the 2006 NHRPL was accompanied by CMS Circular 56 of 20 December 2006, which confirmed that there was no publication of a NHRPL for 2007 and announced that the CMS would "retain the existing 2006 NHRPL as published at constant values in real terms year-on-year (by applying a 4.9% inflator to 2006 prices)".

1.8.8 The result of this process was that various stakeholders, including Netcare, devoted a substantial amount of time, resources and money to the process of making submissions (including complying with the requirements of Circular 69), and submitting to audits, in respect of the 2007 NHRPL, only for these submissions to have no impact on the NHRPL

for 2007. The inflationary adjustment of 4.9% disregarded all submissions made and no regard was had to the true costs of private medical practice.

1.8.9 Matters did not improve with the 2008 RPL. On 23 July 2007, the Minister published the relevant regulations under section 90(1)(u) of the Health Act ("the RPL Regulations").3

1.8.10 There was, however, insufficient time to utilise the scheme introduced by the RPL Regulations for the purpose of determining a 2008 RPL. Indeed this was expressly foreshadowed in the RPL Regulations themselves, since regulation 10 provided that *"[i]n determining the reference price list for the year 2008, the Director-General shall take into account the reference price lists previously determined by the Council for Medical Schemes*".

1.8.11 Accordingly, when the 2008 NHRPL was published by the Department on 16 November 2007, it simply provided for an inflationary increase of 5.4% on the 2007 NHRPL. This inflationary increase was published without allowing affected persons an opportunity to comment on the proposed adjustment.

1.8.12 SAMA objected to the 2008 NHRPL in a press release issued on 11 December 2007. In this press release SAMA stated the following:

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[3] Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of Reference Price List, GG 681, 23 July 2007.

"*The current NHRPL does not take into consideration the realities of the actual practice costs, as well as the deemed equivalent state packages for medical professionals. Information relating to this was submitted to DOH via CMS in 2006. We are extremely disconcerted that this information appears to not have been incorporated in determining the NHRPL thus far.*

The increase in fees suggested by the NHRPL for 2008 of approximately 5.4%, well below the CPIX, is insulting and divorced from economic reality, and of major concern to doctors in the private healthcare sector. Of particular concern is the Department of Health's disregard of private sector cost escalations, as well as the 7.5% salary increases in the public sector.

SAMA is concerned about retaining healthcare professionals in our country and the long-term sustainability of private practice. SAMA has been conducting cost studies to determine the cost of private practices and it is of great concern that most practices are running at a loss, with many doctors in private practice effectively earning less than their colleagues in the public sector.

[SAMA] would like to inform the general public and all medical practitioners in the country of its extreme dissatisfaction with the process followed in determining the NHRPL increase for 2008.

SAMA is gravely concerned and records its extreme displeasure with the unilateral decision to publish the NHRPL without inviting comments in respect of the price list as stipulated in the regulations."

1.8.13 Notwithstanding SAMA's objections, the 2008 RPL was applied.

1.8.14 For 2009, the Department again attempted to establish the benchmark tariff through reliance on the RPL Regulations. This action was challenged on a number of grounds and, as appears from the judgment of Ebersohn AJ[4], the High Court concluded that the RPL process should be reviewed and set aside. The High Court concluded that the process was significantly flawed (and not only because of the absence of appropriate regulations).

1.8.15 In paragraph 230 of its submissions, the Department indicated that there were a number of "*disagreements*" in relation to methodology when it came to private hospitals. However, the Department did not provide sufficient context in this regard.

1.8.16 Firstly, in respect of the issue of "*representivity*", the Department excluded submissions which were made by entities which did not represent more than 95% of the discipline in question. In this regard, the High Court found that this resulted in the exclusion of HASA, notwithstanding the fact that it represented a significant proportion of private hospital service providers.

[4] See *The Hospital Association of South Africa v The Minister of Health & Others; ER24 EMS (Pty) Ltd & Another v the Minister of Health & Others; South African Private Practitioners Forum & Others v The Director-General of Health & Others* 2010 (10) BCLR 1047 (GNP) ("*HASA*"), at paragraphs 115-120.

1.8.17 Secondly, the Court noted that the "methodology" which was published by the Department was ultra vires as it did not apply to all healthcare establishments and simply invited parties (such as private hospital groups) to propose a methodology – for "*prior approval*" for use in costing methodologies.

1.8.18 The Court, however, noted that HASA had made submissions to the Department regarding an alternative methodology (see paragraph 151 of the judgment). However, the Court found that "*these attempts included the exchange of a plethora of correspondence which was largely ignored by the Department and the Director General. It is common cause that, as at the end of 2008 – by when the Director-General had already published an NHRPL for 2009, which included reference price lists for private hospitals – the Director General had neither approved nor rejected the alternative methodology submitted on behalf of HASA. … The correspondence reveals a consistent failure on the part of the Director General to engagement meaningfully with, or listen to submissions from, or thereafter, to provide reasons and rational responses to the proposals submitted by and on behalf of HASA*".

1.8.19 HASA had commissioned Deloitte to prepare the cost benchmarking hospital methodology. Deloitte presented this model to the Department for approval as was required by the regulation. This process culminated in the final communication from the Department on 8 June 2009 followed by communication from HASA on 18 June 2009. The Department then proceeded to publish the 2010 RPL that was merely an inflation on the old

reference prices, notwithstanding the new regulations and guidelines as well as the court process which was already underway. Before a court date had been set the Department published the 2010 RPL, notwithstanding an undertaking not to do so. Judge Ebersohn noted that the DG did so "without advancing any reasons for her attitude" and he was forced to interdict the DG until the final determination of the matter. Deloitte had analysed the impact of applying NHRPL to private hospitals in 2008 and concluded that "Should the NHRPL be used as the basis for reimbursement, it is expected that the industry as outlined above would make a 15.1% pre-tax loss. In other words, for every Rand of money spent by private hospitals, there is a loss of 15c."

1.8.20 The process relating to the RPL reflects the complexity involved in setting reference prices and points to the fact that it is likely to be inefficient for a regulator to try to mimic the flexibility and dynamism of the market in setting tariffs whether these are regulated tariffs or simply "reference" tariffs.