NETCARE OVERVIEW PAPER – 30 APRIL 2015

1. BACKGROUND

1.1 Following the initiation of the Market Inquiry into the private healthcare sector on 29 November 2013 ("**the Inquiry**"), the Panel appointed to conduct the Inquiry published a Statement of Issues and requested submissions from interested stakeholders in respect of the issues raised by the Panel. On 31 October 2015, Netcare filed extensive submissions in relation to the Statement of Issues, which included a number of expert reports from Peter Davis and Margaret Guerin-Calvert from Compass Lexecon, Greg Harman of FTI Consulting and Barry Childs from Insight Actuaries and Consultants.

1.2 Subsequently the Commission published Supplementary Guideline No. 1 on 5 February 2015 which provided, inter alia, that participants in the Inquiry would be provided with an opportunity to evaluate various submissions that had been made by third parties, to respond to any adverse allegations that were made against them and to correct any inaccurate or misleading information contained in the various third party submissions. In this regard, Netcare has requested its various experts to respond to a number of allegations made in certain of the third party submissions. It has also in this document set out its response to certain material allegations.

1.3 Despite the fact that Netcare was afforded additional time by the Panel to prepare its responses to a number of the allegations which have been made, it has not been possible to address each and every allegation contained in the various third party submissions given the vast range and number of third party submissions. Instead, Netcare and its experts have elected to focus on what it considers to be the key issues raised in the third party submissions. (Particularly those which appear in a number of the submissions.) As set out above, detailed rebuttals to various of the allegations made by third parties are contained in four expert reports prepared by Peter Davis, Margaret Guerin-Calvert, Greg Harman and Barry Childs attached hereto as annexures "**E**", "**F**", "**G**" and "**H**", respectively. For purposes of this paper, we will not repeat all of the detail which is provided in Netcare's expert papers, but will simply highlight certain of the key conclusions referred to in those responses.

1.4 While Netcare does not wish to be overly formalistic in taking the opportunity to respond to certain of the third party submissions, it does wish to place on record that its failure to respond to each and every individual allegation referred to in the numerous third party submissions, should not be construed in any respect as an acceptance or admission of any of these allegations and Netcare reserves its rights in due course to challenge or address any allegations which have not been adequately ventilated in its experts reports or in this paper. In particular, Netcare reserves its right to respond to any third party submission which the Commission or

Panel believes is relevant to its findings in respect of this Inquiry. Netcare also intends participating in the oral hearings scheduled by the Panel and will deal with any residual issues at that stage.

1.5 Lastly, we wish to record that certain of the submissions which have been made publicly available by the Commission contain significant redactions of confidential information, which impede the ability of Netcare and their experts to respond fully to the submissions. For example, the Discovery Health submission contains significant redactions at, *inter alia,* paragraphs 60 – 63, 139 – 159, 275 – 283 and 291. It is unclear whether these portions of the submission relate to private hospitals or Netcare and, accordingly, Netcare and its experts are unable at this stage to respond to the contents of these paragraphs or any assertions which are based on these paragraphs. Furthermore, the Mediclinic submission also contains significant redactions, particularly in the annexures (for example, in annexure 5.14, which is an Econex paper on bargaining power, essentially all the figures and tables are redacted, which leads to difficulties in understanding the annexure or responding thereto).

1.6 In addition, it should be noted that it is difficult to respond meaningfully to analyses referred to in certain of the submissions without access to the underlying data. Several of the submissions, for example those of Discovery Health and Medscheme, contain charts which appear to be based on their own data and, self-evidently without access to the underlying data or an understanding of how the

data has been manipulated, it is difficult to comment or respond to those aspects of the submissions.

2. INTRODUCTION

2.1 At the outset, we wish to make a number of preliminary observations in relation to various allegations, which have been made in the third party submissions, but particularly with reference to those contained in the submissions of the Board of Healthcare Funders of South Africa ("**BHF**") and those reflected in the submissions made by the Department of Health ("**the Department**").

2.2 The first observation in relation to the Department and BHF submissions in particular, is that they tend to incorporate a number of broad, sweeping statements, which are generally unsupported by any facts or empirical analysis. For example, the BHF submission contains a number of statements such as "*BHF does not believe that improved competition in the private health sector will improve the position of South African consumers of healthcare services"* and that *"the private health sector is completely out of alignment with health policy in that the former emphasises secondary and tertiary levels of healthcare at the expense of primary and preventive healthcare*." (our emphasis)

2.3 These statements are illustrative of the emotive and sweeping generalisations contained in the BHF submission, which are not underpinned by any clear evidence or facts to support such

statements. To the contrary, the relevant facts undermine the contentions made by the BHF. For example, in relation to the contention that the private health sector is completely out of alignment in regard to primary healthcare, it should be noted that a significant level of primary healthcare is in fact accessible through the private sector. According to the General Household Survey 2010[1], approximately 30% of South Africans access healthcare in the private sector, which tends to be predominantly primary healthcare. (A significant component of private primary healthcare is funded out-of-pocket.)

2.4 Netcare, through Prime Cure and Medicross, is the largest corporate provider of primary healthcare with 87 primary healthcare facilities nation-wide, complemented in selected cases, by pharmacies and day-theatres. Medicross offers, *inter alia*, access to medical practitioners, dentists, visiting specialists, pharmacy, radiology, theatres, pathology and a varying range of ancillary services including, but not limited to physiotherapy, "well-baby", travel, specialised diabetes, hypertension and dietician clinical services.

2.5 Accordingly, it is factually incorrect to allege baldly as BHF does, that the private healthcare sector is "*completely out of alignment with government health policy*" in respect of primary healthcare.

[1] http://www.statssa.gov.za/publications/P0318/P03182010.pdf

2.6 Similarly, the BHF's statement that private healthcare in South Africa is purely "*hospi-centric*" is equally misguided in light of the facts set out above. While it is correct that the PMB regulations tend to be *"hospi-centric"* in nature, given the fact that they are intended to ensure that individuals are covered by their schemes for events which require hospital admission, this does not detract from the fact that a large proportion of the South African population (almost 30%) source primary healthcare services from the private sector.

2.7 The Department makes similarly disparaging statements in respect of the private healthcare sector, for example statements such as "*the system is neither efficient nor fair"* and *"this indicates the extent to which private healthcare provision is hospi-centric, without adequate investment into preventative and cost-effective primary healthcare services*." Neither of these statements is supported by any substantive factual assessment and, like the BHF submission, is simply not consistent with current realities. It is surprising that the Department would suggest that the private healthcare sector is not efficient (without providing any factual basis for this statement), particularly when one has regard to the content of the media articles attached marked "**A1**" to "**A7**", regarding the public sector.

2.8 Another key contention raised by the Department is the suggestion that the Panel should have regard to notions of "*equity*" and the need to establish a unified health system pursuant to its enquiry into private healthcare in South Africa. The suggestion that equity should

be a key consideration in determining health policy in South Africa is not a new proposition by the Department. Similar suggestions were made in the Green Paper in respect of National Health Insurance and, on 20 December 2011, Prof Van den Heever published a paper responding to the Green Paper in which he also dealt with the Department's proposals relating to a single tier system and concepts of "*equity*".

2.9 Prof Van den Heever's assessment of the Department's contentions in this regard are succinctly captured in paragraph 6.10 of his paper as follows[2]:

> *"6.10 The arguments in favour of a "single-tier" system are broadly framed as questions of equity. However, the notion of equity is not a simple one and requires clear arguments explaining what principles of equality or equity are applied in framing public policy choices. They are however raised in very vague terms as both "principles" and "noble goals".*
>
> *"The two-tiered health system of healthcare did not and still does not embrace the principles of equity and access and the current health financing mode does not facilitate the attainment of these noble goals."*
>
> *6.10.1 In the absence of an evidence-based benchmark on what constitutes acceptable levels of equity and access, this is empty rhetoric which allows for interpretations that would in some cases result in absurd policy prescriptions.*

[2] Prof Alex Van den Heever, Evaluation of the Green Paper on National Health Insurance, page 29, para 6.10

6.10.2 For instance, the statement appears to imply that any private demand for healthcare is a deviation from "equity and access". Although individuals can hold such a view, this is not a useful or realistic point-of-departure for the development of public policy."

2.10 Netcare does not believe that it is necessary to traverse issues of equity and the Department's desire for a unified health system in any more detail but will be happy to address this issue more extensively if required by the Panel.

2.11 The Panel will no doubt appreciate that it is difficult for Netcare to respond to high level allegations which are not supported by any detailed reasons and, accordingly, we have sought to respond, on Netcare's behalf, as best we can to a number of the generic statements contained in the BHF and Department papers in particular.

2.12 It should also be noted that certain of the "evidence" referred to by the BHF and Department is either outdated or not sufficiently detailed to allow for a meaningful response. Nevertheless, to the extent possible, these issues have been thoroughly canvassed in the various expert reports. Simply, by way of example, the "evidence" relating to concentration calculations referred to in the BHF paper, is not only outdated and without any meaningful relevance to the current state of affairs in private healthcare, but as pointed out in Ms

Guerin-Calvert's paper, is also not technically or methodologically correct.

2.13 We would, therefore, suggest that the papers submitted by the BHF or the Department should be considered with considerable caution, given the failure to put up any detailed, relevant evidence to support the contentions referred to in their papers. In addition, to the extent that they refer to or rely on economic theory and certain factual evidence, it is respectfully suggested that it is generally either unrepresentative, outdated or not a fair reflection of the existing economic literature or the current factual state of affairs and/or draw overly broad and unsupported inferences from theory to support assertions that competition is unworkable in healthcare. Very little empirical evidence is provided by the BHF to sustain its pre conceived theories. Simply put, the BHF does not present any system-wide data, no recent data, no trend data and no analysis of any depth whatsoever to confirm the assertions made in its submissions. It is interesting to compare this approach to that of Discovery which provides detailed data analysis, which is principally based on recent data.

2.14 A thorough critique of the "*evidence*" relied on in the Department and BHF papers and the economic theory reflected in those papers, is set out in the expert papers of Ms Guerin-Calvert and Dr Davis.

3. SUBMISSIONS RELATING TO CONCENTRATION AND REGIONAL AND LOCAL DOMINANCE

3.1 A number of submissions including those filed by the BHF, Department as well as certain schemes, such as Medscheme[3] have sought to contend that the private hospital market is very concentrated and that the various hospital groups enjoy regional and local dominance. They contend that, as a result of the concentrated nature of the market, private hospitals are able to exert market power in the manner in which they price their services.

3.2 As set out in the various expert reports filed by Dr Davis and Ms Guerin-Calvert, these allegations are largely misconceived and not consistent with all of the relevant facts. In particular, it does not appear that either the Department, BHF or Medscheme performed a detailed analysis of relevant geographic markets or sought to reflect existing levels of competition between hospital groups. Nor have they considered the actual record and empirical evidence of new entry into various geographic areas by new entrants or the various existing hospital groups. As the Panel will be aware, we have already provided the Panel with a detailed assessment in this regard in the form of the initial report submitted by Ms Guerin-Calvert on 31 October 2014. In addition, Ms Guerin-Calvert's rebuttal paper in response to the BHF's submission that "*competition does not work*" in

[3] Medscheme submission, page 3, paragraph 15; Profmed makes similar allegations – see page 11, paragraph 2.54. Discovery also suggests that the hospital and provider markets are concentrated, but does not appear to rely heavily on this aspect of its submissions. (See Discovery submission 17 November 2014, page 144.)

the private healthcare sector, sets out further information in relation to entry and expansion in the various geographic markets identified in her initial report.

3.3 The evidence reflected in Ms Guerin-Calvert's papers clearly demonstrates the extent to which there is competition between the various hospital groups in the private healthcare sector in South Africa in each of the relevant geographic areas. The picture presented in Ms Guerin-Calvert's papers is indicative of a vibrant, competitive and dynamic private healthcare sector (insofar as private hospitals are concerned), which is characterised by new entry, dynamic change and market conditions which are conducive to competition. This primary evidence of the nature and extent of competition in each of the relevant geographic markets set out in Ms Guerin-Calvert's papers has not been challenged at a factual level by any of the information set out in the other public submissions made by third parties.

3.4 Furthermore, the Department in making its submissions on levels of concentration appears to focus its attention primarily on the period 1999 - 2004. This is a fairly static analysis and does not take account of the period since 2004. Dr Davis also points out the fact that Netcare has not been involved in any material merger activity over the last decade. Indeed, according to Econex, national concentration ratios have not changed significantly since 2004.

3.5 Curiously, neither the Department nor the BHF make any meaningful reference to the fact that the markets for medical schemes and medical scheme administrators have become increasingly concentrated over the last decade, but instead have sought to try and focus on outdated figures relating to concentration levels in the private hospital sector only.

3.6 It should also be pointed out that the Department seeks to suggest that there is a link between the increase in private hospital concentration in the period 1999 - 2004 and an increase in private hospital expenditure, which it suggests is evidence of market power on the part of the hospital groups. In his rebuttal paper, Dr Davis points out the various deficiencies in the Department's contentions in this regard, including, but not limited to, the fact that the studies relied on by the Department actually seek to relate medical scheme's hospital costs per beneficiary to concentration without controlling for any other relevant factors. Such an approach is unsound in light, for example, of the findings in the Discovery and Medscheme submissions which report that the main drivers of the measured change in medical schemes' average hospital costs actually relate to changes in utilisation, not hospital price increases. In addition, he notes that hospital markets appear to be local in nature, yet concentration has been measured by the Department on a national basis and it does not explain why national concentration should be expected to be a good measure of a hospital group's overall relative bargaining position.

3.7 Furthermore, although consolidation in the private hospital sector in South Africa occurred primarily in the second half of the 1990s, the Department focuses attention on the period 1999 – 2004. In addition, there seems to be a disjuncture between the nature of the analysis of concentration measures in the form of the HHI calculations performed by Econex and those underpinning the Department's submissions. It is submitted that the Panel will need to carefully weigh up the Econex analysis of private hospital consolidation and concentration against the position adopted by the Department. These issues have been fully canvassed in Dr Davis's paper.

3.8 The Department's contentions that private hospital concentration is related to an increase in private hospital expenditure is also undermined by the Discovery Health submissions which suggest that one of the principal drivers of medical scheme "*inflation"* is attributable to so-called demand side factors (ie. the extent to which members of medical schemes demand more healthcare services from year to year).[4] Indeed, Discovery indicates that demand side factors, "*…are the main reason for volume increases and hence for excess claims inflation. Demand side factors account for 63.2% of excess claims inflation over the period 2008 – 2013. Demand side factors are largely due to adverse selection and, to a lesser extent, a worsening disease profile within the existing medical scheme population. Adverse selection is the process whereby proportionately more high risk, sicker individuals tend to remain in medical*

[4] Discovery Health submission 17 November 2014, page xi

schemes."[5] Furthermore, Discovery also points out that, "*tariff inflation has only been slightly higher than CPI over the period 2008 – 2013, and is not the main reason for claims inflation in excess of CPI. Average annual tariff increases between 2008 and 2013 exceeded CPI by only 0.4% per year (tariff increases of 7.1%, relative to CPI of 6.7%).*"[6]

3.9 In summary, it is respectfully submitted that no empirically sound causal link between changes in pricing and changes in concentration in the late 1990s in South Africa has been demonstrated and that, even if there was evidence of increased concentration in the period 1999 – 2004, this is not particularly relevant to an assessment of current pricing and expenditure levels. Moreover, a comprehensive review of the relevant economics literature provided in Ms Guerin-Calvert's paper undermines the Department's overly broad claims about a systematic relationship between increases in pricing and levels of concentration

4. ASSESSMENT OF BARGAINING POWER

4.1 A number of the schemes and the BHF have sought to contend that medical schemes are not able to bargain effectively with private hospital groups and that, as a result of consolidation in the private hospital sector, smaller medical schemes (in particular) have

[5] Discovery Health submission 17 November 2014, page xi
[6] Discovery Health submission 17 November 2014, page xi

diminished bargaining power and are not able to negotiate effectively with the various private hospital groups.

4.2 Indeed, the BHF has suggested that there are "*accusations that private hospital groups use strong arm tactics especially against smaller medical schemes*"[7]. Apart from unsupported anecdotal references of this kind (which are not supported by any facts), which are not particularly meaningful from an evidentiary perspective, the BHF submission and those of the various schemes which have made similar contentions are devoid of any detail in this regard and should be contrasted with the detailed analysis performed by Dr Davis in respect of bargaining power (set out in both his initial paper as well as in his subsequent rebuttal paper).

4.3 In response to the contention by the BHF that the PMB regime means that medical schemes have no option, but to pay whatever the hospital in question charges and that this contributes to an imbalance in bargaining power[8], Dr Davis points out that the argument that suggests that medical schemes have no bargaining power because they have to pay PMBs, does not address the fact that medical schemes have incentives to manage their costs and can use mechanisms such as DSPs to do so. Bestmed and Profmed's allegation that hospital groups have no incentive to enter DSPs is not consistent with Netcare's evidence which suggests that it actively seeks inclusion in DSP networks.

[7] Paragraph 6.4, page 27 of BHF submission
[8] Para 6.4, pages 27-28 of BHF submission

4.4 It should also be borne in mind that Netcare's tariffs do not distinguish between PMB and non-PMB conditions (as the tariffs are premised on wards, theatres and equipment fees and not the type of condition treated in the ward in question). Dr Davis also points out that the evidence contained in his papers, suggests that network options provide schemes with bargaining power over hospitals; **[Confidential]**.

4.5 Insofar as network options are concerned, Discovery Health submits that, "*network plans give medical schemes countervailing power to negotiate discounted tariffs for inclusion in hospital networks",* although it suggests that this countervailing power is constrained by what it describes as "*limited supply in some regions"* and competition between open schemes.[9] Indeed, Discovery indicates that, "*the use of network plans by some medical schemes does provide important elements of price competition between hospital groups. As described in more detail below, DH has used detailed cost analytics to identify the most efficient hospitals in different regions of the country and has used this information to negotiate and build two separate hospital networks (the Delta hospital network and the KeyCare network) which are offered within some plan options of DHMS, as well as some options in certain restricted medical scheme clients."* Discovery also indicates that hospital expenditure associated with these plans exceeded R1.5 billion and that the revenue derived by

[9] Discovery Health submission 17 November 2014, page xiv

hospital groups in this respect was regarded as extremely valuable by the hospital groups concerned.[10]

4.6 In addition, Dr Davis also demonstrates both in his original submission and in his rebuttal paper that an analysis of bargaining power requires a careful consideration of each side of the negotiations outside options, not a simplistic appeal to a national concentration measure from one side of the negotiation process. Moreover, the evidence presented by Ms Guerin-Calvert in her original and rebuttal papers does not support the view that the three large hospital groups face weak competitive constraints, generally, or weak competitive constraints from independent hospitals. To the contrary to the Department's and other submissions which present limited if any empirical analyses of competitors, the papers by Ms Guerin-Calvert present detailed information on these alternatives.

5. SUBMISSIONS RELATING TO EXCESSIVE PRICING, RETURNS AND PROFITABILITY

5.1 A number of the third party submissions, particularly those of the BHF and Department, seek to contend that there is evidence to suggest that private hospital groups are enjoying increasing levels of profitability[11]. In order to seek to support their contentions in this regard, the Department and the BHF rely largely on certain high level calculations reflected in a desk top analysis by Genesis referred to in

[10] Discovery Health submission 17 November 2014, page 102
[11] DOH para 69, page 30

their papers, without performing any independent analysis of their own to verify Genesis's high level and desk top views.

5.2 Mr Harman from FTI has responded comprehensively to the Department and BHF allegations in this regard in his supplementary report and has pointed out various flaws in the Genesis methodology and calculations. FTI has demonstrated that the Department does not seek to validate or verify the findings of, or methodology used by Genesis and simply adopts certain of its conclusions (which are reached on a preliminary basis by Genesis), without any independent analysis. It should also be noted that the Department does not provide any additional or new information in respect of the economic profitability of private hospitals, other than simply to rely on the Genesis document.

5.3 From the publicly available submissions, it would appear that Mediclinic is the only other party, other than Netcare, which has conducted a detailed profitability analysis and that no other entity, apart from Mediclinic, has sought to engage in a reliable and detailed analysis of hospital profitability.

5.4 Insofar as the BHF has sought to rely on increases in the share prices of a number of the private hospital groups to contend that this is an indicator of profitability[12], FTI points out that, while Netcare's share price has increased over the 12 months to June 2014, this

[12] BHF para 6.8

does not constitute evidence of excessive returns and is broadly in line with similar increases across the JSE. FTI also points out that using a share price as a barometer of profitability is inherently unreliable, given the fact that there are many factors that affect share prices and that share prices often reflect market expectations as much as they say anything about existing levels of profitability. Accordingly, both the factors relied upon and the conclusions drawn by the Department and BHF in respect of hospital profitability should be carefully scrutinised in light of the telling criticism that is set out in the FTI rebuttal report.

5.5 In addition, the Department also seeks to engage in an international price comparison exercise in the graphs set out in figures 9 to 15 of its submissions[13]. These graphs seek to plot the "*costs*" of various healthcare services in South Africa and compare these on an "*affordability-adjusted*" basis to some international data. Comparison figures were evidently obtained from the International Federation of Health Plans ("**IFHP**"). Prices for the selected services are adjusted for Gross Household Income ("**GHI**"), which is suggested to be a basis on which the costs of the services can be adjusted to take account of affordability.

5.6 The Department's graphs and methodology have been assessed by Barry Childs from Insight Actuaries and Consultants. The logic which underpins the Department's analysis is that higher prices can be paid

[13] DOH submission, page 36 - 39

by households with higher incomes. Mr Childs points out that this choice of methodology is not a standard practice in economics and gives rise to a number of anomalies including the following:

5.6.1 The implicit assumption is that the "*price*" for privately provided healthcare goods and services should be relative to income. In other words, in countries with lower levels of income, the price should be lower, even if the cost of providing the service in question is exactly the same. This is not a standard economic approach to determining the economic value of a good or service.

5.6.2 The dataset within the IFHP analysis includes a mix of public and private systems. This makes it difficult to draw meaningful comparisons between prices or costs between public sector and private sector prices, without a detailed understanding as to the underlying methodology as to the manner in which the prices have been determined (i.e. to ensure that apples are being compared with apples).

5.7 Given the different nature of the private and public provision of healthcare, there are also significant questions as to whether these "*prices*" could ever be meaningfully compared. The public sector entails the provision of healthcare services by the Government to citizens, whereas the private sector involves private entities investing money into facilities which provide healthcare services to fee paying people.

5.8 Since the GHI figures are national, adjustments would need to be made for all countries to reflect the relevant sub-population, and not just for South Africa, for the comparison to be meaningful. In addition, the Department analysis recognises that the incomes of medical scheme members is not representative of the overall population in South Africa by making an adjustment (doubling the figure for Gross Household Income). Given the degree of income inequality in South Africa, this doubling is, unfortunately, an insufficient adjustment to the figures. Should such an adjustment be made it should be based on representative data. A brief consideration of income and expenditure survey data from Statistics South Africa indicates that households with at least one member on a medical scheme have incomes 2.7 times higher than the overall average household income in South Africa.

5.9 In other words, the attempt by the Department to draw comparisons with other countries cannot be relied upon to draw any conclusions as it lacks the detail, which would be required to make it capable of proper analysis and it also suffers from a variety of major methodological flaws.

5.10 The Department also purports to rely on an analysis it has performed, which it suggests reflects that private sector prices in South Africa compare unfavourably relative to upwardly-adjusted public sector prices. In this regard, the Department has sought to compare prices in the private sector based on the Uniform Patient Fee Schedule to

certain prices which it alleges to represent the rates charged in the private sector. For the detailed reasons set out in the report filed by Barry Childs, the use of the Uniform Patient Fee Schedule is also not appropriate in relation to private sector pricing.

5.11 In particular, given the findings of the Constitutional Court in *Law Society of South Africa & Others v the Minister of Transport & Another* (CCT 38/10), it is surprising that the Department has chosen to use Uniform Patient Fee Schedules for the purposes of the analysis.

5.12 In that case, Deputy Chief Justice Moseneke noted that the Minister of Transport had prescribed the applicable tariff at which the Road Accident Fund would be liable to accident victims for the cost of medical and healthcare services as being the Uniform Patient Fee Schedule[14].

5.13 He then held further that the evidence in that matter demonstrated that "*[91] I have no hesitation in finding that the UPFS tariff is a tariff that is wholly inadequate and unsuited for paying compensation for medical treatment of road accident victims in the private health care sector. The evidence shows that virtually no competent medical practitioner in the private sector with the requisite degree of experience would consistently treat victims at UPFS rates. This simply means that all road accident victims who cannot afford private*

[14] Paragraph 27 of the decision.

medical treatment will have no option but to submit to treatment at public health establishments". (our emphasis)

5.14 The Court then concluded that "*[99] I am satisfied that the UPFS tariff is incapable of achieving the purpose which the Minister was supposed to achieve, namely a tariff which would enable innocent victims of road accidents to obtain the treatment they require. UPFS is not a tariff at which private health care services are available; it does not cover all services which road accident victims require with particular reference to spinal cord injuries which lead to paraplegia and quadriplegia. The public sector is not able to provide adequate services in a material respect. It must follow that the means selected are not rationally related to the objectives sought to be achieved. That objective is to provide reasonable healthcare to seriously injured victims of motor accidents*." (our emphasis)

5.15 It would appear that the same logic would apply in relation to the rationality of seeking to use the Uniform Patient Fee Schedule as a basis for assessing whether the costs of providing hospital services in the private sector were excessive. This is particularly so given the concerns which are raised regarding the use of the Uniform Patient Fee Schedule as set out in the supplementary report of Barry Childs.

5.16 In light of these considerations, it is equally difficult to understand the basis on which Medscheme recommends[15] that minimum reference

[15] Medscheme submission, page 21

prices for hospitals be set according to UPFS levels, given the fact that Medscheme does not articulate any logical rationale for this proposal, allied with the fact that the Constitutional Court appears to have already found that it would be irrational to benchmark certain types of private hospital treatment according to UPFS levels.

5.17 These facts suggest that the UPFS tariff is not an appropriate or useful benchmark in comparing private sector hospital prices with public sector prices and it is respectfully suggested that the Department's analysis in this regard is fundamentally flawed.

5.18 Moreover, it is also curious that the Department should seek to make such submissions given its own experience with the so-called "*Folateng*" wards in certain of the public sector hospitals.

5.19 These wards operated on the basis of using similar tariffs for medical schemes as those used by private hospitals. Netcare does not have precise information in this regard (which the Commission could obtain from the Department), but is led to believe that the rates charged by the Department in relation to these Folateng wards are not structurally lower than the rates which would be charged by private hospitals. Notwithstanding these tariffs, the operating losses which have been incurred in the Folateng wards have resulted in the Minister of Health publically announcing his intention to close down the Folateng wards owing to an inability to recover the costs of operating these wards.

5.20 This is despite the fact that these wards did not have to cover their capital costs, electricity and water which are all covered by the public hospital in its normal budget. This appears from the following statement by Jack Bloom which has been included for ease of reference. Once again, in the interests of completeness, the panel would be able to obtain all of the relevant information in this regard from the Department.

> *"Posted on July 24, 2014 by Inga Ndibongo*
>
> *Jack Bloom MPL*
>
> *DA Gauteng Shadow Health Spokesman*
>
> *The Folateng private wards in Gauteng Hospitals have lost R77.3 million in the last three years, and have yet to be scrapped despite instructions by National Health Minister Aaron Motsoaledi.*
>
> *This is revealed by Acting Health MEC Barbara Creecy in reply to my questions in the Gauteng Legislature.*
>
> *These private wards have been running for more than 10 years at the Charlotte Maxeke Johannesburg, Helen Joseph and Sebokeng hospitals. They were meant to generate a profit in order to subsidise public patients, but my estimate is that they have lost more than R500 billion (sic) in total over the years, including capital expenditure.*
>
> *According to the reply, R198 million was spent on the Folateng wards at Charlotte Maxeke between 2011 and 2013, but only R149.5 million revenue was collected, making a loss of R48.5 million.*

R10.4 million was spent on Folateng at Helen Joseph during this period, with a loss of R1.1 million and at Sebokeng R34.8 million was spent with revenue of only R7.1 million, leading to a R27.7 million loss.

The bed occupancy is sometimes as low as 20% at the Folateng wards in Sebokeng Hospital. At Helen Joseph Hospital, 38% of Folateng beds are occupied, and the average for Charlotte Maxeke is 73 percent.

Earlier this year, doctors at the Chris Hani Baragwanath Hospital wrote to Health Minister Aaron Motsoaledi requesting that empty Folateng beds be made available for public patients as some severely ill patients had to be sent way from public wards."

5.21 Furthermore, in the BHF submissions, an attempt is made to compare costs for certain procedures in the private and public sectors in relation to child birth[16]. However, the BHF also does not provide any detail in its analysis on the source data or what utilisation statistics were used for the calculations of private and public sector costs. An article published on the BHF's website does, however, concede that "*the UPFS (Unified Patient Fee Structure) is not reflective of the actual costs of providing the benefit as it does not take into account costs such as infrastructure, etc*".[17]

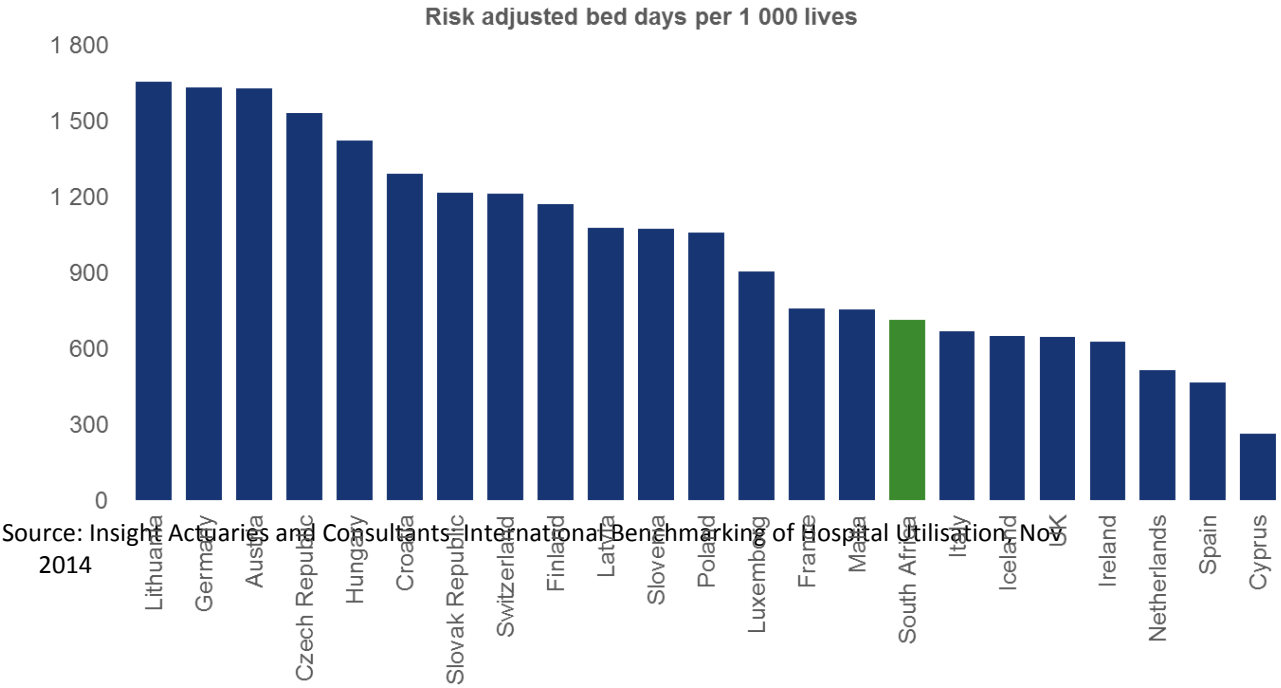
5.22 Medscheme also compares admission rates at South African private hospitals to some other countries. While referenced, the source, richness and accuracy of the Reinsurance Group of America (RGA)

[16] BHF submission, paragraph 6.3
[17] http://www.bhfglobal.com/national-health-insurance-%E2%80%93-finding-model-suit-south-africa

data is not discussed. The basis of country selection is also not discussed. There is only mention of potentially varying market dynamics at play in different countries and methodological differences are evident in the way in which different countries approach data and admission definitions. Based on work done for HASA by Insight[18], it is evident that cross country comparisons of admission rates and length of stay statistics are affected by definitions, in particular how day cases and new-borns are treated. These differences need to be well adjusted in order to make results meaningful.

5.23 According to Insight Actuaries and Consultants SA ranks 8 out of 23 countries in terms of total beds days/patient per 1000, on a risk adjusted basis. This accounts for both the admission rate as well as efficiency on length of stay. In fact, a relatively high admission rate would be expected in a market with private health insurance and private delivery, as compared to a publically-funded or publically-delivered system where rationing is likely to be tighter. All of the comparator countries have a large public sector coverage or a high percentage of health care expenditure in the public sector. Among the comparator countries, the average extent of public sector coverage is 77%, and the average percentage of health care expenditure in the public sector is 72%. This appears from the following graph:

[18] Insight Actuaries and Consultants, *International Benchmarking of Hospital Utilisation; how does the South African private hospital sector compare?*, 2014



Source: Insight Actuaries and Consultants, International Benchmarking of Hospital Utilisation, Nov 2014

6. BHF'S ALLEGATIONS REGARDING THE 1998 AGREEMENT BETWEEN RAMS AND HASA IN 1998

6.1 As the panel will be aware from the detailed submissions which have previously been made by Netcare, Netcare charges members of medical schemes or privately paying patients for the services which it provides in its facilities on the basis of certain tariffs for ward, theatre and equipment (often referred to collectively by the acronym "*WTE*"). Given the fact that patients will also require pharmaceutical products as well as surgical and consumable products when they are treated at Netcare facilities, Netcare will have to procure these products and supply them to patients. Pharmaceutical products are supplied to patients on the basis of the single exit price at which Netcare

acquires the products (Netcare does not charge a dispensing fee for products which are dispensed to patients in the wards or theatres).

6.2 Similarly in the case of surgicals and consumables (including medical devices), Netcare supplies these products to customers at their net acquisition cost (i.e. the cost price at which Netcare procures the products from the suppliers in question). In other words, Netcare does not make any profit on consumables, surgicals or medical devices.

6.3 There has been a suggestion in the submissions made by the BHF[19] that the private hospital groups did not move to zero cost pricing in relation to surgicals and medicines despite an alleged agreement reached with RAMS in 1998 in relation to the reduction in the then mark-up on list prices and that this meant that they had significantly "*over-charged*" medical schemes in the period preceding the introduction of single exit pricing and the adoption of net acquisition pricing by Netcare. On the basis of this assertion, it is then stated in very emotive terms by the BHF that "*their business ethic is such that they do not care about the consumer. All they care about is yielding higher returns on investment for their shareholders*".

6.4 It is concerning that the BHF seeks to suggest that adverse inferences should be drawn regarding the conduct of private hospital groups in relation to these developments in the 1990's, but as

[19] BFH submission, page 31 onwards

appears from a proper consideration of the actual facts, the assertions by the BHF are based on an incorrect understanding of the relevant facts. It is further strange that these submissions which relate to developments more than 14 years ago are deemed to be relevant to the healthcare inquiry which is seeking to understand the nature of competition in the healthcare sector in 2015.

6.5 This is a very significant inquiry by the Competition Commission and the panel has indicated that it seeks to conduct an investigation on the basis of facts. Emotive allegations which are made, particularly where they are made on the basis of incorrect facts, do not assist the panel in its investigation. Moreover, the fact that the BHF believes that it is appropriate to make such emotive and potentially damaging allegations on the basis of incorrect facts, also calls into question the weight which should be attached to the remainder of the submissions which have been made by the BHF.

6.6 Prior to discussing the matter in greater detail, it should be noted that the gravamen of this aspect of the BHF's submission is simply that the private hospital groups did not comply with an alleged agreement relating to an increase in ward, theatre and equipment tariffs in exchange for a movement to net acquisition pricing of pharmaceutical and surgical products in 1999 and that this resulted in "*overcharging*" in the period thereafter.

6.7 Unfortunately, in order to deal with these incorrect allegations of the BHF, it will be necessary to set out an account of the historical interactions of RAMS and HASA in relation to these issues. Many of the people who were involved in these interactions have subsequently retired. Fortunately Netcare has been able to obtain copies of certain of the relevant documents and one Netcare employee was involved in some of the relevant interactions.

6.8 It should be appreciated that the events which are discussed in the submissions of BHF are said to have occurred in 1998 which was at a time when the reference tariffs were determined by way of multilateral (or collective) negotiations between the representative organisations of the private hospital groups (HASA) and the medical schemes (RAMS - Representative Association of Medical Schemes - the predecessor to the BHF). As the panel will be aware, this collective or multilateral negotiation process ceased in 2002 following an investigation by the Competition Commission.

6.9 In the early 1990s, HASA submitted a proposal to establish a transparent pricing model for the determination of private hospital tariffs, based on a notional 168 bed hospital (as set out below, because of the lack of information on the part of day hospitals, RAMS applied a 25% discount to the tariffs for day hospitals). The parameters of the model were agreed by HASA and RAMS. The model explicitly included a margin on the list price of drugs and surgicals as part of the income of the private hospital groups.

6.10 Specific reference was made to the fact that pharmacy 'profits' were used to achieve the required return on investment for the private hospital groups. In other words, the profit on pharmaceutical and surgical products effectively subsidised the ward, theatre and equipment tariffs which were agreed between RAMS and HASA. As an aside, it should be noted that the existence of such a cross-subsidy is not unique to South Africa and Netcare is aware of the fact that in certain other countries such as India and Brazil, the profit made on the supply of pharmaceuticals and surgicals constitute the bulk of profits of certain of the private hospital groups in those countries.

6.11 During the period 1990 to 1994, the price at which pharmaceuticals were supplied to patients by private hospital groups was based on the Trade/Bluebook (usually referred to as the "*Bluebook*") price (being the ex-manufacturer price) plus a mark-up of 50%, less a discount of 10%. This amounted to an effective mark-up of 35% on the Bluebook price, plus a dispensing fee of R2.49 to R2.70. There were additional charges added for "*breaking of bulk*" and for "*container fees*".

6.12 At the end of 1994, an agreement was reached between HASA and RAMS to reduce this 35% mark-up on the Bluebook price to a 10% mark-up, plus a dispensing fee of R2.90, which came into effect on 1 January 1995. As this would result in a reduction in the returns of the private hospital groups, the parties agreed on an adjustment to

the relevant ward, theatre and equipment fees, resulting in a cost neutral transfer of profits made in respect of the mark-ups to ward, theatre and equipment fees. The day hospitals did not agree to reduce the mark-up on pharmaceuticals, which meant that the differential between the tariffs charged by the day hospitals and full service hospitals was further accentuated.

6.13 In 1998, an agreement was reached to remove the 10% mark-up on the Bluebook price. This arrangement came into effect on 1 January 1999. Indeed, the Joint Agreement between HASA and RAMS concluded on 9 December 1998, provides in clause 7.1 that "*The term Net Acquisition Price of Pharmaceuticals shall mean the trade unit price as reflected in what is colloquially known as the Blue Book as applicable from time to time*".

6.14 This appears clearly from a letter dated 10 September 1998 in which DM Brennan on behalf of RAMS noted that "*In line with national policy, we are desirous of reducing the mark-up on medicines and consumables in hospital down to the wholesale figure and in fact once the new act has been enacted, looking at true exit prices. We are fully appreciative that the medicine component cross-subsidises your theatre and wards. In an effort to reduce the mark-up which, as you know, we look upon as a perverse incentive, we will be happy at increasing the ward and theatre fees by an equitable amount. This could be in line with the calculation recently presented to RAMS*".

6.15 In 1998 there were also discussions on reducing the price of pharmaceuticals to take account of discounts which were being granted to hospital groups off Bluebook prices by pharmaceutical manufacturers. There was, however, no agreement reached between the parties in this regard at the time. From the excerpts of the 10 September 1998 letter there is no doubt that RAMS was aware of the existence of the discounts off the Bluebook prices at the time. It was also clearly recognised that the further reduction of the prices at which pharmaceutical products were supplied to medical scheme members would require a further adjustment to the ward, theatre and equipment fees.

6.16 The joint agreement reached in 1998 for 1999 included the principle of cost neutrality in respect of changes to hospital tariffs arising from the reduction in the mark-ups from the Bluebook price. In correspondence from RAMS on 4 December 1998 it was noted that: "*The Net Acquisition Price of pharmaceuticals is currently listed in the 1999 Pharmaceutical Scale of Benefits, as Blue Book prices as at 31/10/98*."

6.17 Some of the correspondence relating to this agreement between the parties has been attached as annexure "**B**".

6.18 At a subsequent meeting between representatives of HASA and RAMS on 21 January 1999 there was a dispute regarding "*the use of the term 'blue book' vs 'net acquisition price*". The minutes of the

meeting recorded that the RAMs Scale of Benefits (RSOB) was based on zero mark-up off Bluebook price and that "*any deviation to the use of a reference price for reimbursement purposes OR the true net acquisition price would require a further increase in ward and theatre and needs to be negotiated*".

6.19 This indicates very clearly that there was no agreement between RAMS and HASA in relation to a move to net acquisition pricing in 1999 (it simply related to the use of the Bluebook price without mark-ups) and the tariff schedule which was subsequently used by Netcare was that which was agreed between RAMS and HASA.

6.20 It should be noted that when single exit pricing was subsequently introduced and when Netcare later moved to net acquisition pricing of surgicals, consumables and medical devices, it specifically engaged medical schemes and medical scheme administrators in relation to the impact which this would have on Netcare and agreed revised ward, theatre and equipment tariffs to take account of the regulatory and contractual developments.

6.21 As the detailed analysis by FTI has indicated, Netcare's ward, theatre and equipment tariffs do not result in Netcare's profitability being above what would be expected to prevail in a competitive and sustainable market. In other words, a detailed and empirical analysis (as opposed to the untested assertions by the BHF) demonstrates

that the BHF's assertions in this regard are simply incorrect and mischievous.

6.22 In the following sections, we address several specific allegations raised by certain of the third party submissions. We set these responses out in some detail in the following paragraphs, and rely on the attached expert opinions to provide greater detail in response to various aspects of the third party submissions.

7. SOUTH AFRICAN DAY HOSPITAL ASSOCIATION ALLEGATIONS REGARDING "COST SHIFTING"

7.1 In the submissions which were made by the South African Day Hospital Association ("***the Day Hospital Association***"), there are allegations that private hospital groups are involved in a "*cost shifting strategy, which has enabled the large private hospital groups to channel patients away from the more cost-effective day hospitals into their general-care hospitals*"[20].

7.2 It would appear that certain of the assertions made by the Day Hospital Association are premised on an incorrect appreciation of the historical development of the tariffs in the 1990's (indeed, it would appear from the Day Hospital Association's submissions that it does not have information relating to the 1990's). This fundamental error on the part of the Day Hospital Association is significant as it

[20] Day Hospital Association submission, paragraph 2.1.1

undermines the factual underpinning for certain of the assertions, which are made in the submissions by the Day Hospital Association.

7.3 Given the fact that the Day Hospital Association seeks to make adverse assertions on the basis of this incorrect factual understanding, it is once again necessary to provide the healthcare inquiry team with information relating to events which occurred nearly 30 years ago. It is not clear on what basis the Day Hospital Association could have imagined that this information would be relevant to the current healthcare inquiry or why it has not provided the healthcare inquiry team with a correct version of the relevant facts.

7.4 The principal basis for the argument by the Day Hospital Association appears to be the historical differentiation between the prices for so-called Category 57 and Category 58 hospitals. These tariffs were published in the Government Gazette in the early 1990's. However, the differential between the tariffs for Category 57 and Category 58 hospitals in the early 1990's did not have any logical basis. Initially, we are advised that the difference between a Category 57 and Category 58 hospital was the fact that a Category 57 hospital did not have an ICU or a Cathlab. While there should not necessarily have been a difference between the costs associated with a general ward or theatre in a Category 57 and Category 58 hospital, two separate tariffs had evolved and over time the differences between the tariffs could not be logically reconciled.

7.5 As a result of interactions between RAMS and the representative organisations of the various hospital groups (at that time being the NAPH (Afrox [now Life] and Presmed and Mediclinic) and the RAPH (Clinic Holdings [now Netcare] and various Independents) and the Day Hospital Association (then called the Day Clinic Association), a cost based tariff was introduced in the early 1990s (as described above). However, because of the fact that the Day Hospital Association did not have sufficient information to justify the tariffs which they sought to charge, this resulted in RAMS applying a 25% discount to the acute hospital tariffs in relation to day hospitals. The differential was accentuated when the Day Hospital Association did not agree to reduce the mark-up on pharmaceutical products from 35% to 10% in 1995.

7.6 Against this backdrop, it should be noted that Netcare is not able to understand the purpose of the insertion of the table reflected at paragraph 4.9 of the submissions of the Day Hospital Association as the submissions do not explain what the table is meant to demonstrate. Once again, it is not clear what purpose is served by including information which relates to developments which occurred nearly 23 years ago.

7.7 It should be noted that Netcare's tariffs for short term and long term hospital treatments have historically increased uniformly through negotiations with funders. As such, the assertions of the Day

Hospital Association in this regard are simply not applicable in the case of Netcare.

7.8 Through its investment in Medicross, Netcare also has an interest in a number of day theatres (13). It has, however, found that the use of unattached day theatres has been lower than it has been suggested would be the case by the Day Hospital Association. There may be various reasons for this including concerns about risks on the part of surgeons. For example, if there are complications which arise in procedures carried out in a day theatre, the patient would have to be transferred rapidly to a full service hospital and this may pose a risk to the patient.

7.9 While dealing with the submissions of the Day Hospital Association it should be noted that they make a number of unsubstantiated assertions. For example, in paragraph 2.2 of the submissions, it is suggested that "*the three major groups are already pressurising specialists who currently work at their facilities, not to utilise day surgery facilities*". No evidence is provided for this assertion and Netcare is not aware of any such conduct.

7.10 It would also appear from the submissions of the Day Hospital Association that it wishes the panel to preclude private hospital groups from offering day surgery services or facilities.[21] The suggestion is further underpinned by the suggestion that a cost

[21] Day Hospital Association submissions, paragraphs 2.3, 5.3 and 7.3

differential should be maintained between day hospital tariffs and those of full service hospitals[22]. These suggestions would appear to be an anti-competitive attempt on the part of the Day Hospital Association to limit competition faced by its members in order to reserve the offering of day surgery facilities to members of the Day Hospital Association. This is a strange proposal to make to a Competition Authority and would appear to be an attempt at limiting the ability of private hospital groups to respond dynamically and to innovate in the provision of healthcare in South Africa.

7.11 There are also a number of unsubstantiated submissions made by the Day Hospital Association[23] which have been addressed in other portions of these submissions and are clearly incorrect. It should also be noted that many of the submissions are simply unsubstantiated (or bald) assertions without any factual or evidential underpinning or simply paraphrasing of statements made by third parties.

7.12 There is also a suggestion in paragraph 6 of the submissions that "*imperfect information*" regarding the tariffs charged by private hospital groups undermine the ability of day hospitals to compete with full service hospitals. It is difficult to understand the logic of this assertion as medical scheme administrators and medical schemes will know precisely what the differences are between the tariffs charged by day hospitals and full service hospitals. The assertions

[22] Day Hospital Association submissions, paragraph 4.14
[23] Day Hospital Association submissions, paragraphs 2.4 and 4

by the Day Hospital Association in this regard also do not take account of the fact that medical scheme administrators have developed very sophisticated administrative and managed healthcare systems. Moreover, Ms Guerin-Calvert's report comprehensively addresses and refutes claims that departure from a model of *"perfect competition"* including *"imperfect information"* renders competition in private healthcare markets unworkable.

8. ANAESTHETIC GASES

8.1 In paragraph 6.14 of the BHF's submissions it is suggested that the private hospital groups had charged incorrectly for medical gases.

8.2 It should be noted that the anaesthetic agents are incorrectly referred to as gases. They are in fact volatile agents, in a liquid form, which require to be passed through a vaporiser with a combination of Oxygen and medical air in order to be delivered to the patient. They are not prescribed or dispensed in the manner of ordinary medicines (they are "*dispensed*" in a wholly different form (gas) to the form in which they are acquired (liquid)). Secondly, volatile agents are not prescribed in advance of treatment (ie. an anaesthetist would have no idea before administering the liquid agent how much will in fact be used on a patient).

8.3 The billing of anaesthetic agents was historically based on a per minute calculation since the introduction of the Scale of Benefit Tariff

schedules. This was simply due to the fact that there was no way to measure the utilisation of the anaesthetic agent.

8.4 The Netcare practice of per minute billing in place at the time of the BHF allegations was consistent with the methodology provided in the CMS published NHRPL.

8.5 This appears from the following extract from the CMS NHRPL for 1 January 2006 (for ease of reference, we have not included the actual per minute prices as the excel spreadsheet is then difficult to include).

NATIONAL REFERENCE PRICE LIST IN RESPECT OF PRIVATE HOSPITALS (PRACTICE NUMBERS "57" OR "58") AND UNATTACHED OPERATING THEATRE UNITS/DAY CLINICS (PRACTICE NUMBER "77") WITH EFFECT FROM 1 JANUARY 2006
Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified
Halothane (Halothane): per minute
Ethrane (Enflurane): per minute
Forane (Isoflurane): per minute
Isofor (Isoflurane): per minute
Ultane (Sevoflurane): per minute
Suprane (Desflurane), per minute
Aerrane (Isoflurane): per minute
Alyrane (Enflurane): per minute

Fluothane (Halothane), per minute

8.6 This approach was also consistent with historical billing practices at the time for anaesthesia due to the fact that no equipment was available at that stage to measure the actual utilisation on a patient theatre event basis.

9. PERVERSE INCENTIVES AND RELATIONSHIPS BETWEEN SPECIALISTS AND HOSPITALS

9.1 In the Executive Summary of the Department's submissions[24], it is noted that: "*Although most health professionals seek to act in the best interests of patients, the current coding, billing and remuneration system creates an environment that supports profit-maximisation through perverse incentives, including the provision of unnecessary services and upward price inflation*".

9.2 In paragraph 101 of its submissions, the Department contends that it is important to deal with what it describes as "*the perverse incentives that emerge in the hospital-specialist relationship*". It does not clearly articulate what it means in this regard apart from suggesting that the current reimbursement environment in terms of which providers receive reimbursement based on the nature of their activities and that

[24] DOH submissions, page 3

they are fully reimbursed in respect of PMBs [25] creates an environment that is conducive to perverse incentives.

9.3 Firstly, the PMB environment is a function of the legislative and regulatory regime which is currently in place and cannot be attributed to any of the large private hospital groups.

9.4 Secondly, in order to suggest that perverse incentives are linked to the hospital-specialist relationship, the Department, in essence, is suggesting that health professionals may act in ways which are not consonant with their ethical duties and with good medical practice. Netcare believes that the vast majority of specialists behave ethically and in keeping with their professional obligations and do not believe that this is a legitimate approach for the Department to adopt. Of course, to the extent that a medical practitioner acts in a manner which is not consistent with his or her ethical duties, this could give rise to disciplinary actions being taken by the Health Professions Council of South Africa.

9.5 In 2012 Netcare implemented a project to monitor the effective utilisation of care levels in hospital. This included evaluating whether patients admitted to Intensive Care Wards and High Care Wards required this level of care and whether the length of stay of the patients in these wards and general wards was longer than was necessary.

[25] DOH submission, para 274

9.6 This project utilised an international scoring mechanism to assess each patient's required level of care during his or her stay in hospital. The project evaluated over 30% of patients admitted to Netcare facilities from 2012 and continues today. The objective of the exercise in the Netcare context is to evaluate whether patients are receiving the appropriate level of care within the hospital setting, as well as exploring the opportunity to move patients to lower care settings within hospitals efficiently and that patients are discharged timeously. The intent of the project was for the hospital case managers to engage with the treating doctors if the scoring system indicated that the patient could be moved to a lower level of care or be discharged from the hospital or if there were other unrecorded clinical reasons for keeping the patient in the higher level of care.

9.7 **[Confidential]**

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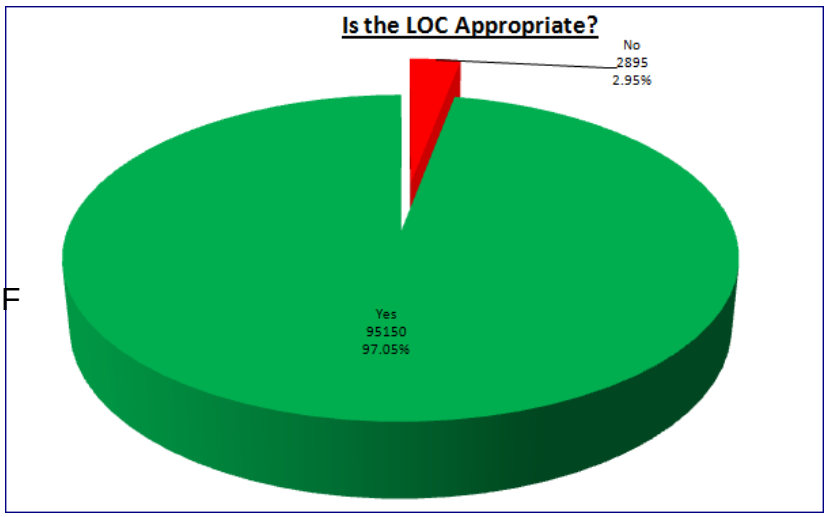

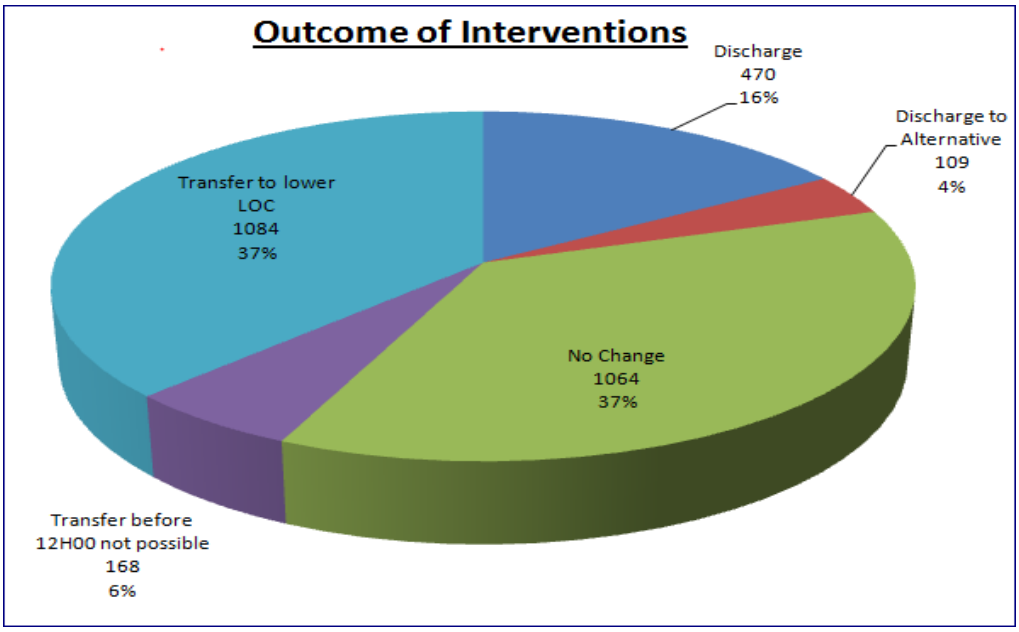

9.8 **[Confidential]**

9.9 **[Confidential]**

9.10 In the BHF's submissions there appear to be suggestions that there is no evidence that "*private healthcare sector delivery is more efficient, accountable, and sustainable than public sector delivery*"[26]. Moreover in paragraph 6.3 it is stated that "*there is no proper monitoring and control to ensure the quality of healthcare services they deliver relative to the price*".

9.11 Given the obvious and well recognised differential between the levels of care which are offered at private facilities as compared to public facilities, it is remarkable that the BHF would seriously suggest that

[26] BHF submissions, paragraph 5.21

there can be any question that the provision of healthcare in the private sector is in an entirely different league to the delivery of healthcare in the public sector in South Africa. This has been addressed elsewhere in these submissions.

9.12 However, it should also be noted that Netcare spends a significant amount of effort on improving the quality of outcomes in its facilities. In this regard, it should be recalled that the treatment of a patient is primarily determined by the treating practitioner and the relevant medical scheme. However, Netcare's Director of Quality Leadership, a founding member of Best Care Always, has adopted a number of quantifiable metrics to ensure that it is improving the quality of care within its facilities.

9.13 The following extract from the Quality Leadership and Clinical Governance Report provides some indication of the steps which are being taken in this regard:

> "***307*** *quality measures in Netcare across all divisions in Netcare*
> ***74%*** *of the 307 measures had a year-on-year improvement*
> **35%** weighting for quality measures on Executive Balanced Scorecards
>
> ***86%*** *overall Quality Assurance Score in Hospital division (up from 80% in 2013)*
> ***2*** *Netcare Milpark and Netcare Union First hospitals in SA to be awarded Level 1 Independent Trauma accreditation*

96% *score for transplant regulatory audit outcomes*

100% compliance to Independent Monitor evaluation at all four facilities in Lesotho

8.48 *average overall rating by hospital patients – out of 10 (US Hospital Consumer Assessment of Healthcare Providers and Systems (US HCAHPS = 7.1)*

76% *of patients would "definitely recommend" Netcare services and facilities*

81% *pain management patient feedback score – up from 79% (US HCAHPS = 71%)*

66% *medication information on indications and side effects – up from 61% (US HCAHPS = 64%)*

90% *patient and family satisfaction rate at Lesotho Queen 'Mamohato Memorial Hospital*

11.3% *reduction in total adverse events per 1 000 patient days since 2012*

0.09 *central-line infection rate per 1 000 line days (down from 2.25 in 2011)*

2.17 *ventilator-associated pneumonias per 1 000 ventilator days (down from 8.43 in 2011)*

5.5% *acute myocardial infarction (AMI) in-hospital mortality per 100 cases across 17 hospitals (down from 7.7% in 2011)*

12.1% *reduction in antibiotic usage (defined daily doses per 100 bed days) across all hospitals*

0.7% *paediatric mortality rate as a percentage of admission (2013: 0.9%)*

5.5% *paediatric deaths as a percentage of admissions (2013: 6.1%)*

4.8% *total in-patient mortality (2013: 5.8%)*".

9.14 Other parties which have also sought to suggest that there are perverse incentives inherent in the private healthcare environment

include the likes of Profmed, which has sought to suggest that the relationship between hospitals and medical specialists is inherently conflicted and perverse on account of the fact that they allege that hospitals need to build relationships and garner the support of medical specialists through the offering of a variety of incentives to generate increased utilisation of facilities in order for hospitals to achieve certain profit targets[27]. The Profmed submission does not offer any factual basis to underpin its contentions in this regard.

9.15 In particular, it does not specify what "*incentives*" it is referring to and how these incentives are alleged to increase utilisation of hospital facilities. Accordingly, it is very difficult for Netcare to respond to such generalised allegations apart from unequivocally indicating that it does not offer "*incentives*" to specialists in order to generate increased use of its facilities.

10. **MEDICAL EQUIPMENT AND DEVICES**

10.1 The BHF also contends that the listed hospital groups use more expensive inputs than are necessary [28] and overcharge medical schemes in relation to medical devices[29]. In fact, medical schemes have benchmarked various inputs and found Netcare to be efficient in this regard. Indeed, BHF's own analysis of net acquisition prices of medical devices and materials reflected on page 58 of the BHF

[27] Profmed submission, page 11, para 2.57

submissions, illustrate that Netcare was the cheapest in 5 of the 7 items referred to in the chart.

10.2 Moreover, the example which BHF relies on in respect of air filters (page 30 of the BHF report), is 8 years old and does not contain any factual evidence to verify the conclusion reached by BHF. No additional data in this regard has been supplied by BHF.

10.3 In addition, a benchmarking exercise conducted by Netcare of prices of medical devices purchased by Netcare (SA) and BMI (UK), shows that manufacturers charge significantly more for the equivalent product in South Africa than they do for the same product or device in the UK. Accordingly, there may be various reasons why the prices of medical devices are higher in South Africa than they are in other countries, which has absolutely nothing to do with excessive pricing or market power of private hospital groups, but is rather a function of the differential pricing regime which is applied by medical device companies in South Africa.

11. **THE SO CALLED MEDICAL "ARMS RACE"**

11.1 The Department in particular contends that private hospitals spend unnecessarily on cost-enhancing technologies in order to attract more physicians and patients[30] and seeks to contend that both economic theory and certain studies conducted in the 1980s in the

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[28] BHF, page 30
[29] BHF, para 11.2, page 56
[30] DOH, para 90, page 40

United States supports its conclusion that what it describes as the "*medical arms race*" is inefficient and does not result in equivalent health gains in outcomes.[31]

11.2 Firstly, besides referring to outdated studies conducted in the United States and hypothetical game theory exercises, which have no relevance to actual market circumstances in South Africa, the Department presents no reliable evidence to support its contentions in this regard. Dr Davis points out that the Department's discussion of the relevant economic literature is incomplete and ignores more recent research which comes to the opposite conclusion. A general appeal to the literature, therefore, does not support the Department's contentions – rather the literature suggests a far more careful empirical analysis would be required if one were to attempt to establish whether such theoretical possibilities have any relevance in real-world circumstances.

11.3 Dr Davis also points out that because hospitals are heterogeneous and services can vary along many dimensions, investments in equipment and technology have the potential to increase consumer welfare, inter alia by increasing access to a facility, by reducing waiting times, by increasing geographic accessibility to quality healthcare and improving patient outcomes. As a policy matter, experience strongly suggest that the right starting point for economic policy is that competition is typically associated with good outcomes

[31] DOH submission, para 98, page 43

for consumers in terms of lower prices, more choice, and greater innovation. Therefore, it would be quite wrong to conclude that investments in medical equipment and technology are inefficient and do not produce desirable health benefits in the complete absence of any reliable or meaningful data or analysis to the contrary.

11.4 This issue has been addressed in detail in the supplementary reports of Dr Davis and Ms Guerin-Calvert.

11.5 Interestingly, as far as new medical technologies and new speciality drugs are concerned, Discovery Health makes the point that, while these technologies may create demand for healthcare services where none existed before, and where new biologic drugs contribute to increased healthcare expenditure, that they are providing alternatives for patients in circumstances where there were no alternative treatments previously. In other words, one would need to carefully evaluate the welfare-enhancing benefits that patients derive from these new technologies and new drugs as against the increased costs borne by the private healthcare system. This assessment requires a great deal of empirical evidence before any definitive conclusions could be reached in this regard and, it would not appear to us, that any of the third party submissions contain sufficient analysis in this regard for any meaningful conclusions to be drawn on this issue.

12. PRICE REGULATION AND COLLECTIVE BARGAINING

12.1 One of the key features of the Department's submission is the view expressed in section 3 of its paper that as a consequence of what it perceives to be "*systemic market failure*" and "*misallocation of resources*" in the private healthcare sector, there should be regulatory intervention and regulation of private healthcare pricing on the grounds of what it describes as "*economic efficiency and social justice*".[32]

12.2 The Department recommends[33] that "*a regulatory framework could be established in order to facilitate fair price negotiations between providers and medical schemes informed by an assessment of cost structures and quality measures*." In particular, the Department proposes that a negotiation framework is established by it, with the aim of supporting central collective bargaining using a cost-based tariff structure [34] as the point of departure. In addition, the Department proposes that a "*chief tariffs negotiator for health services tariffs*"[35] should be appointed, who would receive costing information from all the stakeholders in the industry[36]. In conclusion, the Department indicates that it strongly recommends price regulation of the hospital sector.

12.3 Similarly, the BHF also contends that the price of healthcare in the private sector should be regulated.[37] The BHF also argues that

[32] DOH submission, para 31
[33] DOH, section 9, para 273
[34] DOH submission, para 245
[35] DOH submission, paragraph 247
[36] DOH submission, paragraph 248
[37] BHF submission, paragraphs 3.2 and 3.3

competition does not lead to lower prices in the private healthcare sector and that '*competition in the health sector is about who can charge the highest price thanks to information asymmetry, the healthcare consumer is always in a weaker position than the healthcare provider and is rarely if ever in a position to vote with his feet*."[38] The BHF rather emotively contends that the supply side of the private healthcare market is "*out of control*".[39]

12.4 In response, Ms Guerin-Calvert points out that the starting premise for the Department's views are misconceived, because they mischaracterise the importance of some deviation of a real-world market from a theoretical perfectly competitive market. Few (if any) markets exhibit the characteristics of perfect competition, yet the majority are not subject to public utility style price regulation.

12.5 She also points out that the Department submissions overstate the extent to which countries have chosen price regulation of privately funded healthcare and private insurance-private provision over reliance on competition and private negotiations between the respective parties. For example, the list of countries cited by the Department in support of its contention that there are many countries internationally which regulate private healthcare prices includes the United Kingdom, where private health insurance-private hospital transactions are not regulated. Indeed, Ms Guerin-Calvert points out that, contrary to the Department's assertions, many countries rely on

[38] BHF submission, paragraph 3.3
[39] BHF submission, paragraph 6.16

competition rather than price regulation to discipline pricing for private hospital sector prices, particularly where the transaction involve private insurers/consumers and private hospitals.

12.6 The Department also claims that countries regulate prices through either "*centrally administered pricing*" or "*negotiation process*."[40] To outline the price-setting methodology used by various countries, in Table 4 of its submission the Department of Health summarizes Table 3 of "*the OECD report*" (i.e., Kumar et al (2013)), which relates to the "*Regulation of prices/fees of* ***specialists' services***" paid for basic primary health coverage. The first point to make is that this is clearly not applicable to hospital services.

12.7 Further, the Department also claims that in most cases the "*price determination involves collective negotiation among associations of doctors, hospitals or health insurers.*"[41] It supports this claim by referring to the following excerpt from Kumar et al (2013):

> *"It is generally accepted across OECD countries that governments or public authorities play a proactive role in fostering the setting of prices in order to reach policy objectives…."*[42]

12.8 However, the role of collective bargaining across the OECD countries is applicable predominantly to the public sector. While the OECD

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40 Department of Health submission, para. 205.
41 Department of Health submission, para. 206.
42 Kumar, A. et al. (2014), para. 18.

paper recognises that "*price setting is a common feature of* ***public*** *health care systems*",[43] it also emphasises that:

> *"Countries with a similar role for private health insurance such as that in South Africa do not prescribe prices in the private sector but they also tend to have much larger public health care systems. None of the eight countries where private health insurance plays a similar role to that in South Africa (Australia, Finland, Ireland, Italy, New Zealand, Portugal, Spain and the United Kingdom) directly intervened to regulate prices of medical services settled between private health insurers and private hospitals.´*[44]

12.9 Moreover, Ms Guerin-Calvert points out that it is neither more efficient nor necessary to have regulated prices for private hospital services. Indeed, many experts have cautioned about the substantial unintended consequences and inefficiencies associated with unnecessary price regulation. These points are augmented in Dr Davis's paper. For example, the Department's suggestion that there should be a return to collective bargaining under the auspices of a chief tariffs negotiator, is likely to become mired in the same levels of protracted negotiation and delay experienced with collective bargaining in a trade union environment.

12.10 There are certainly no guarantees that a reversion to collective bargaining under the supervision of a government appointed negotiator is likely to be any more efficient or conducive to lower prices than the current environment or address adverse selection that

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[43] Kumar, A et al, para. 13.
[44] Kumar, A et al, para. 12.

has plagued the medical scheme industry following the introduction of open enrolment and community rating in the Medical Scheme Act of 1998. In particular, there is no substantive evidence or analysis to support the Department's proposition that government intervention in private healthcare price setting, would be any more effective than unregulated private negotiations.

12.11 It should also be borne in mind that the Department's references to studies and articles at the OECD in respect of the competitive effects of mergers and increased concentration, actually demonstrate the point that competition in healthcare, rather than regulation, provides for efficiency and price competition.

12.12 Insofar as the BHF's contentions that competition leads to high prices is concerned, this rather counter-intuitive statement is not supported by any data or evidence other than to contend that this is a result of what the BHF describes as "*information asymmetry*"[45].

12.13 In response to the BHF's submissions in this regard, a number of contrary features should be considered. Firstly, the bulk of private hospital patients are represented by managed healthcare providers and administrators, with three administrators and three schemes representing the vast majority of medical scheme beneficiaries. Accordingly, the contentions in respect of information asymmetry should be viewed in the context of a sector where managed care

[45] BHF, para 3.3

organisations and administrators have access to significant levels of disaggregated data and information and are often better placed than many of the hospital groups to review a conspectus of the relevant data; given the fact that they receive data from all of the various hospital groups.

12.14 For example, Discovery Health employs numerous actuaries, analysts and managed care personnel to monitor and review data in order to make informed decisions in the private healthcare sector. Other schemes and administrators and managed care organisations likewise employ similarly skilled people to review the data and information they receive from private hospitals and medical specialists. Accordingly, the relevant managed care organisations, schemes and administrators are often extremely well informed.

12.15 It is, therefore, not correct to contend, as BHF does, that asymmetric information flows are a prominent feature of private healthcare in South Africa. It should be pointed out that medical schemes have comprehensive schedules of Netcare's negotiated tariffs across over 65 000 lines relating to tariffs, drugs and surgicals. This is evidence of schemes having access to Netcare data and information, which they can utilise in their interactions with Netcare.

12.16 Secondly, the BHF also suggests that healthcare is an "*inelastic good*"[46] with the result that providers have significant pricing power.

[46] BHF submission, page 63, para 3.7

However, the submissions by Discovery and Medscheme demonstrate that the key drivers of cost increases are not related to private hospital price increases, which represent a relatively small component of overall cost increases. Indeed, price increases of hospital services relative to CPI are often a function of components over which private hospitals have little control, such as the price of medicines, medical devices, nursing and pharmacists costs and electricity and related variable costs.

12.17 Netcare publishes its private tariffs online and charges private self-pay patients at Net Acquisition Price and Single Exit Price. While the latter are not published, Netcare charges medical schemes and private self-pay patients the same rates for drugs and consumables.

12.18 In paragraph 6.11 of the BHF submissions the strange suggestion is made that "*that private hospitals focus on greater returns rather [than the] promotion of access to care is supported by the investment in private beds in areas where the money is rather than where the need is*". This appears again to conflate the role of the private and the public sector. The private sector depends on being able to raise capital to invest in the construction of hospitals and the provision of services. It is therefore, dependent on the need to attract investors who have choices about whether and where in the world they invest their capital. A system which is not dependent on private capital is not a private healthcare model, but a public healthcare model. The

fact that the BHF is not able to appreciate this fundamental difference between the two models is concerning.

12.19 Importantly, insofar as the debate in respect of the potential reintroduction of collective bargaining is concerned, Discovery Health has made some important submissions in this regard. Discovery contends that the implementation of any form of collective negotiation of hospital and facility tariffs would "*harm competition in several ways"* including reducing price competition for participation in network arrangements, weakening incentives for improvement in efficiency and innovation in delivery models, reducing competition between hospitals and alternative care facilities and increasing the risk of collusive practices between hospital groups.[47]

12.20 Moreover, Discovery Health also suggests that the reintroduction of collective bargaining would damage competition between open medical schemes which compete with one another to reduce hospital, facility and pathology prices and would also damage competition between administrators for administration of open and restricted schemes.[48]

12.21 In summary, Discovery suggests that, should the process of collective negotiation which was stopped in 2004 be reintroduced, not only could it facilitate collusion in the private healthcare sector but, the greatest risk of a return to collective negotiation would be that it

[47] Discovery Health submission 17 November 2014, page xxviii
[48] Discovery Health submission 17 November 2014, page xxviii (See also pages 319 and 322 – 325.)

would contribute to tariff inflation and "*…thus aggravating the already significant inflationary pressures on medical schemes outlined in this submission."*[49] Given the fact that Discovery is far and away the largest open medical scheme in South Africa, and Discovery Health is the largest administrator in the country, one would suggest that careful regard would need to be given to Discovery's submissions in this regard.

13. REFERENCES TO THE UK PRIVATE HEALTHCARE MARKET INQUIRY

13.1 In paragraph 6.6 of its submissions, the BHF contends that in the UK Competition Markets Authorities ("**CMA**") report into privately funded healthcare services in the UK, that Netcare was sharply rebuked by the competition authority in the UK for anti-competitive practices[50]. The BHF also contends that the UK authority found that private hospital groups such as BMI, HCA and Spire were found guilty of setting prices that are substantially and persistently higher than the actual cost of the services that they provide[51]. The BHF concludes on this issue by stating that it has "*no reason to believe that private hospitals conduct their affairs differently in South Africa*."[52]

[49] Discovery Health submission 17 November 2014, page 319
[50] BHF submission, para 6.6
[51] BHF submission, para 6.7, page 28
[52] BHF submission, para 6.8, page 29

13.2 There are a number of observations which can be made in respect of the rather cavalier and factually inaccurate statements made by the BHF in this regard.

13.3 First, Netcare was never referred to by the CMA on account of the fact that Netcare does not operate in the UK under the "*Netcare*" brand, but simply has an equity interest in the BMI group. Secondly, the CMA's analysis of local private hospital markets did not survive careful scrutiny, which is implicit in the fact that the CMA reduced the number of proposed divestitures by BMI from 11 divestitures at the Provisional Findings stage to no divestitures by the time of publication of the Final Report[53]. This significant climb-down by the CMA calls into question the reliability and accuracy of the CMA's findings in respect of BMI, including its comments on alleged "*consumer detriment*". Furthermore, analytical and statistical errors made by the CMA in its insured price analysis in respect of the HCA hospital group have also forced the CMA into a second climb-down[54] and to concede that its conclusion regarding an adverse effect on competition and subsequent divestment decision in respect of HCA should be overturned by the Competition Appeal Tribunal ("**CAT**").

13.4 It is telling that either the BHF is not aware of all of the relevant facts relating to the UK inquiry, or it has simply chosen to provide a selective and inaccurate account of the relevant facts. Relevant extracts from the final CMA report and the CAT ruling in HCA

[53] CMA Private healthcare market investigation Final report (2 April 2014), page 12-6, paragraph 12.21
[54] Paragraphs 13, 14 and 16 of the CAT Ruling

International Limited v CMA & others[55] are attached hereto for the Panel's ease of reference as annexures "**C**" and "**D**", respectively.

14. RESPONSE TO SUGGESTIONS RELATING TO SO CALLED "SUPPLY INDUCED DEMAND"

14.1 In its submissions, Discovery Health raises the concept of "*supply induced demand*". It is noteworthy that Discovery Health attributes only a small part of increased utilisation to what it refers to as "*supply induced demand*". However, there appear to be a number of methodological difficulties arising from the manner in which Discovery Health seeks to allocate a portion of the increase in utilisation to so-called "*supply induced demand*".

14.2 In its submissions, Discovery Health discusses a theoretical framework for understanding variations in the supply of healthcare services by region (using Discovery Health's own derived catchment regions) and then seeks to use this high-level analysis to sustain an argument that a portion of the increase in utilisation can be attributed to supply induced demand. Given the methodological flaws in Discovery Health's analysis, it would appear that no such conclusions can be drawn.

14.3 At the outset, it should be noted that the catchment areas used by Discovery Health for its analysis are Discovery Health's own creation and are not commonly used throughout the industry. In other words,

[55] CAT case number 1228 – 1230/6/12/14

other schemes (and/or administrators) would not necessarily allocate their members to these same catchment areas.

14.4 There are several difficulties that arise from the approach Discovery Health has adopted when considering regional variation in resources. Discovery Health bases its analysis on the number of beds per 1,000 members (just short of 4 acute hospital beds per 1,000 members). This figure (a national figure) is derived from using publicly available information relating to all hospitals beds and all medical scheme members at a national level. Discovery Health then seeks to extrapolate from these figures to derive regional figures for its catchment areas.

14.5 While it is possible at a national level to compare the number of beds to the number of beneficiaries, it is significantly more difficult to do so at a regional level. To do so accurately would require having information in relation to the total number of medical scheme beneficiaries by each of these catchment areas. The information relating to total medical scheme membership in each of Discovery Health's catchment areas is not in the public domain. In order to determine variations in supply by region accurately it would be necessary to know the total medical scheme membership per catchment area. It is also unlikely that Discovery Health has the same share of medical scheme members in each region, which will also affect the calculation of variations in supply. For example, the Discovery Health share could be very high in some areas (such as

Johannesburg) and very low in others (such as, for example, East London).

14.6 The difficulty is, therefore, that the alleged variation in bed days per 1,000 shown is a function not only of the hospital beds in the area, and the Discovery Health beneficiaries in the area, but also of the Discovery Health market share of all medical scheme lives in the area in question, which is an unknown. Since the variation in market share per region is unknown, the inferences based on the variation in bed days per 1,000 in each region cannot be relied upon.

14.7 Discovery Health seeks to illustrate its views on so called "*supply induced demand*" by reference to the impact which the opening of a new hospital, Hillcrest, had on hospital utilisation in the surrounding area. It should be noted that Discovery Health has raised Hillcrest, and other examples with Netcare before. At the time, Netcare raised a number of significant questions arising from the preliminary analysis which had been performed by Discovery Health to which Discovery Health did not reply. These questions related to the methodological underpinning of the analysis performed by Discovery Health, as well as the fact that the opening of the Hillcrest hospital did not appear to have the impact suggested by Discovery Health on nearby Netcare hospitals.

14.8 The observations noted by Discovery Health in respect of the Hillcrest example could well be explained by other factors. Discovery

Health cannot simply seek to ascribe any and all changes to the observed utilisation of hospitals in this area to the opening of one new hospital when other potential causes have not been properly analysed.

14.9 The graphs used in the Discovery Health analysis also cause confusion by showing the results on a monthly basis which makes it difficult to establish whether there are any underlying trends (because of the volatility of the results plotted on the graph). In any event, the graphs would appear to undermine the argument being advanced by Discovery as the alleged increase in utilisation in the area commences before the new hospital was actually opened. In fact, without the solid line which has been inserted on to the graph to indicate when the hospital was opened, it would be difficult to establish from the graph when the new hospital was actually opened. The admission rates and length of stay continue to increase at roughly the same rate before and after the opening of the new hospital. Accordingly, it would appear that there is no causative relationship between utilisation changes and the new facility being opened. The analysis presented also fails to consider differences in the levels of demand in each area. Normative results are not presented, so it is not clear whether utilisation in the Hillcrest areas was below expected levels and increases in utilisation simply bring utilisation into line with other areas. In order to make a more accurate study of variations in supply and demand drivers per region, more complete information would be required, including regional

medical scheme membership, complete information on the supply of facilities and providers, and information in relation to the occupancy levels of healthcare facilities.

14.10 Lastly, Discovery Health's approach to ascribing increases in utilisation to supply side factors, or supply induced demand is methodologically problematic. Discovery Health has a wide range of tools (which it has used in various public presentations) to measure demand and burden of disease changes in a nuanced way, but in relation to its purported analysis of "supply induced demand" it chooses to use only demographics and chronic status to adjust for the risk profile of beneficiaries. Discovery Health states that the supply side impact is calculated as being the plan mix adjusted increase less the tariff increase less the demand side impact. In other words, the supply side factors are calculated as the remainder, rather than being explicitly or specifically derived. There are a number of problems with this approach. It means that the supply side is grouped with any other factor contributing to increases in utilisation other than those quantified by Discovery Health's demographic, chronic and plan mix adjustments. Given the importance of this issue it would be preferable to calculate any specific supply side driver of utilisation explicitly. Notwithstanding the fact that it may be difficult to perform such an analysis, it is not correct simply to ascribe the balance of utilisation increases to supply side drivers.

14.11 In conclusion, it does not appear that Discovery's suggestions relating to so called "supply induced demand" are methodologically sound, nor does it seem that from the evidence presented by Discovery that any conclusions in support of its claims are warranted by the evidence.

15. **CONCLUSION**

15.1 In conclusion, in the time available to it, Netcare has sought to respond to certain of the key allegations which have been raised in various of the third party submissions. In particular, Netcare has sought to focus on various aspects of the submissions made by the BHF and Department in particular, which contain a variety of unsupported and unsubstantiated contentions that appear to disclose a distinct bias in relation to private hospitals.

15.2 Accordingly, we would suggest that the Panel should cautiously interrogate the BHF and Department submissions with a view to determining whether their views in respect of market power, collective bargaining and price regulation have any evidential basis and whether when weighed against the evidentiary material supplied by parties such as Netcare, one could objectively reach the conclusion that a reasoned case has been made out for introducing a system of price regulation to combat so-called "*market failure*".

15.3 We respectfully submit that the overwhelming weight of the evidence set out in the various expert papers and submissions by Netcare,

read with submissions by parties such as Discovery Health, amongst others, is to the effect that there is no rational basis for introducing a system of price regulation of private hospital and related services; let alone what would seem to be the vastly inefficient and wholly untested proposals by the Department to introduce a system of price regulation overseen by a pricing commissioner.

15.4 Our client intends dealing with these issues in more detail at the public hearings scheduled by the Panel and wishes to thank the Panel for the opportunity to set out its rebuttal submissions in respect of certain of the third party submissions which have been made to the Panel.

15.5 For the Panel's ease of reference, our client has also prepared brief submissions in relation to certain individual submissions by various medical schemes which are contained in appendix 1 hereto, as well as a short overview of the RPL process which has been referred to in a number of submissions including those of the Department.