SECTION 59 INVESTIGATION

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COUNCIL FOR MEDICAL SCHEMES OFFICES, CENTURION

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Section 59 Investigation

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PROCEEDINGS RESUME

CHAIRPERSON 1: Mr Tembinkosi Bonakele, the Competition Commissioner will be presenting next. Mr Bonakele, are you by yourself or with a team?

MR BONAKELE: I am with, it's Mapato Rakudu [indistinct] Ramokgopa.

CHAIRPERSON 1: Alright, can we just – and both of you will be talking or only one person will be talking?

MR RAMOKGOPA: We will both be talking.

CHAIRPERSON 1: Alright, now let's do this. Let's take the oath for both of you. So, will you start and then I and then your name?

MR BONAKELE: I, Tembinkosi Bonakele.

CHAIRPERSON 1: Swear that the evidence I shall give.

MR BONAKELE: Swear that the evidence I shall give.

CHAIRPERSON 1: Shall be the truth.

MR BONAKELE: Shall be the truth.

CHAIRPERSON 1: The whole truth.

MR BONAKELE: The whole truth.

CHAIRPERSON 1: Raise your right hand and say, so help me God.

MR BONAKELE: So, help me God.

CHAIRPERSON 1: Thank you. Can you do that – sorry, let me just get your surname right.

MS RAMOKGOPA: Ramokgopa.

CHAIRPERSON 1: Ramokgopa, okay. So, Ms Ramokgopa, will you also just take the oath and say, I, your name?

MS RAMOKGOPA: I, Mapato Ramokgopa.

CHAIRPERSON 1: Swear that the evidence I shall give.

MS RAMOKGOPA: Swear that the evidence I shall give.

CHAIRPERSON 1: Shall be the truth.

MS RAMOKGOPA: Shall be the truth.

CHAIRPERSON 1: The whole truth.

MS RAMOKGOPA: The whole truth.

CHAIRPERSON 1: Raise your right hand say so help me God.

MS RAMOKGOPA: So, help me God.

CHAIRPERSON 1: Thank you very much. Mr Bonakele, I think you should decide how you want to structure your presentation.

MR BONAKELE: Thank you very much, Chair. I will do the first part of the presentation and my colleague will… continue from there and I'll come back for the conclusions.

CHAIRPERSON 1: Thank you.

MR BONAKELE: I should say that we come from the Competition Commission and my colleague is part of the technical team that is supporting the inquiry, the health market inquiry that the Commission is currently undertaking. The inquiry is conducted by an independent panel led by Justice Ngcobo. A lot of what we present here is what is in their provisional report. But the… final report is only due by end of September and so they… may as

you would appreciate, change their views on some of the things here including the recommendations. But really, we thought it might help because they have done a lot of work already in this area.

We will also give you the… complaints we have received in…in the area also to give you a sense of what we are… handling. But at this stage, we should say that these are not necessarily the final views of the… panels. But they are based on what is in the public domain and what we have…what we – and the…the final conclusions are also our… own views.

So, the… inquiry itself that the Commission has done was motivated by a high and increasing expenditure in… private health care as well as reduced access to the sector and we… have had now the provisional findings published in… July and currently the…the inquiry is undertaking stakeholder consultations.

And the focus is on private health care which comprises a very complex set of inter-related stakeholders who interact in various ways and who must interact in order to provide this…this service. In fact, those intersections and interactions are the ones that cause a lot of complexity in dealing with…with the sector. So, the inquiry tried to break it down into three main groupings of providers. The first one dealing with health care facilities. These would be your – mainly, hospitals and day hospitals.

The second one being providers. By providers, we mean the specialists as well as general practitioners. There are also other providers like nurses and so on but these two are the most

significant from an expenditure point of view. And then the third category is that of funders, which are, in the case of South Africa, largely, medical schemes as well as medical administrators. They are also brokers who play a role.

The structure of the… health care system which also played a significant role in us deciding to do the inquiry, we have in South Africa, a dual… system of health care. We have a public sector which is accessed by about 84% of the population as well as the private sector, which is accessed by about 16% of the population and we also, if I may refer to the slide, you will note that the number of people who access private health care and these are people with medical insurance, has remained stable from about 1980. And so, has not increased that much whilst the number of people who are reliant on the public sector has been increasingly…increasing steadily over that period.

We also note in the background that these two, that is the public sector and private sector, in health care consume approximately 50% of the total health expenditure. So, 16% effectively of the population that accesses medical care through private health care utilize 50% of the available resources for health care.

South Africa, as a country spends about 8% of GDP on health care, which is comparable to developed countries, OECD countries in particular and is higher than most developing countries. So, if you are benchmarking us against those countries you will find

that we are spending on average, what is recommended as a best practice but what we have is a… distribution problem and not the total availability of… funds …for the sector.

The – I… have already set out the…the various players in…in the sector but I have provided a more substantive slide that describe for you who… are in the… funding side of the market. We know that these funders are the ones who would compensate either the practitioners for the service provided or the consumers where the consumers or…or patients paid out of pocket and on the other side is the… practitioners who would ordinarily claim from the medical funders using a practitioner number and we will explain the implications of…of that as we go along.

We also have noticed that some of the…. facilities which is the hospitals in the private sector are not allowed to employ doctors. But there are doctors that are based at the hospitals so at the facility itself and we'll talk about what the likely implications of these are. We also do have some of them who own shareholding in the… facilities. That also has some implications as far as the incentives of contracting with certain providers is concerned. So, my colleague will proceed from here.

ADV WILLIAMS: May I interrupt you for a second just to ask a question about the…the work that the panel has done and that you have done. Do you know anything about the racial demographics of both practitioners on the one hand and scheme

membership on the other? Or do you know where one would find that?

MR BONAKELE: Perhaps my colleague may have an answer to that but as far as I know we didn't collect data on… the racial profile of people involved but my colleague can maybe help with that.

MS RAMOKGOPA: Thank you, Chair. We… as Commissioner has mentioned, we haven't broken down the distribution of practitioners by race. But we understand that generally there is a lot of practitioners that are GP's, black practitioners or practitioners that are from disadvantaged [indistinct] disadvantaged backgrounds that are likely [] GP's. And then specialists where there is [indistinct] a shortage of specialists.

Okay, so I'm going to in, deep into how the practitioner market is structured. These are central to the consumption of health care services. They generally comprise of GP's, specialists, allied practitioners and pharmacists. Our investigation focused largely on GP's and specialists because they account for the largest population of practitioners and the bulk of the health care expenditure.

Practitioners operate in different forms of practice. You've got solo practices. This is where a practitioner will have his own individual practice and then you have group practices. We largely find those from radiologists [] and pathologists. They will have group practices and then they organize themselves in practitioner associations that would exist to represent the interest of

the practitioners and then some of them are employed in the public sector but those that are employed in the public sector and wish to practice in the private sector, they operate through [indistinct] agreements. These are the remuneration work outside the public service.

And then for practitioners to practice and to be reimbursed and verified in the sector, they need to be allocated a practice number through the BHF's practice numbering system. And in terms of regulation, they are regulated by the Health Professionals Act, so it identifies and classifies and state the roles and scope of practice for the different practitioners. This largely happens through self-regulation in terms of the ethical rules by the various professional boards. So, you would have a professional board for paediatricians, for gynaecologists and the like.

In terms of the distribution our analysis, this is based on 2015 figures and there might have been a slight change. But we don't think that the figures have changed materially and as well, we noted that in South Africa, there is no proper data collection method and as such, it was very difficult to verify some of the figures but these are the estimations that we could collect.

So, we found that a [indistinct] between the public and the private sector, we've got 0.3 medical practitioners and 0.1 medical specialists per thousand population. And then when you focus on the private sector alone, we've got 1.75 private sector practitioners per thousand in short population.

And then the GP's are distributed relatively even across the short population. It's just under one per thousand population and then, you find that the specialists are more concentrated in provincial hospitals and metropolitan area. So, in certain areas particular the rural areas, we don't have specialists at all. So, the referral has to go from rural areas into the metropolitan areas.

This is just the graphical representation of the medical practitioners per province area. I mean it's just to re-emphasize the point that we are making that it's largely the metropolitan areas or provinces that have a large number of practitioners and it cuts across the board.

So, in terms of the industry interactions, the practitioners are the point of entry into the health care system. Ideally, the health care pathway to the private health care starts with the visit to the GP. So, the GP will assess the patient's condition, diagnose and recommend treatment of the condition. And then if necessary then they would refer to the specialist for treatment of the condition that they have diagnosed and then if the condition requires admission of the patient to the hospital, then the choice of the hospital will be influenced by where the specialist is practicing.

However our analysis found that in South Africa, this pathway is not necessarily followed where we find that patients have direct [] access to specialists and have direct access to a

hospitals so which we find that it's also a driver of health care expenditure in that the role of GP in particular has been minimised and private…primary and preventative care has also been minimised so there is a lot of hospi-centric treatment happening in South Africa. And then practitioners have specific relationships and interactions with other players, but before we get to that we just want to show in particular on the funder's side the market shares. So, we've got two types of medical schemes in South Africa. We've got the open and the restricted [] medical schemes. In terms of the open medical schemes, we've got four main players, which is Discovery, Bonitas, Momentum and Bestmed. This is based on the number of beneficiaries.

And then on the restricted medical scheme side, we've got three main players, which is Gems, Polmed. Oh sorry, I forgot to mention the market shares. So, Discovery in terms of the open medical schemes, it's at 56%. Then you've got Bonitas at 15%, Momentum at 6%. Bestmed at 4% and then the restricted medical schemes, we've got Gems at the top at 26%. Polmed at 13% and Bankmed at 6% So, those are the main schemes in the markets.

And then we've got the administrator market. The administrator market is linked to the scheme markets. So, they do the administration for the schemes and also, largely, you find that most of the administrators do the negotiations for tariffs and the contracting of practitioners. And then the main administrators that

we have is Discovery Health at 40 – 40.4%, Medscheme at 38.6% and Momentum Health at 4.6%.

So, with regard to their interaction so we've got the practitioner at the top right there.

ADV WILLIAMS: May I just ask a question about the previous slide?

MS RAMOKGOPA: Okay.

ADV WILLIAMS: So, when you are calculating the market share of the administrators, how – I'm just trying to figure out how to formulate the question because we know that Discovery Health administers a number of schemes and obviously Medscheme does the same. Is that determined by the number of members they represent? Is that market share determined by the number of members they negotiate on behalf of …?

MS RAMOKGOPA: Yes. So that figure would include all the schemes that Discovery Health - they administrate and negotiates for.

ADV WILLIAMS: Okay.

MS RAMOKGOPA: Okay so in terms of industry interaction you've got there practitioners at the top right. The practitioners interact with the consumers in terms of provision of health care services. In terms of the their relationship with the funders it's largely determined by the tariff determination processes, the preferred provider network and the reimbursement models between the funder and the practitioners. The practitioners also

interact with the health care facilities where they have lease or rental agreements. I'm Dr Ramokgopa, I need to practice at a particular facility. So, I'll approach the facility and negotiate a rental agreement.

In some instances you'll find that a facility or practitioners have shareholding in the facilities where they operate. They will grant them a particular shareholding. Alternatively, you'll have facilities that have been set up by the practitioners and in that regard, they will then have shareholding in the facilities. There are also other financial incentives between the facilities and the practitioners. It may be in terms of them providing equipment, providing the practitioners with the location fees or support [indistinct] or study loans and the like.

These also influence how the practitioners relate to the facilities. Then the facilities on the other side, will then also interact with the funders in terms of tariff determination and then being part of designated provider networks and also reimbursement models.

So, I am going to focus now on the interaction between practitioners and funders. So, practitioners interact with medical funders in the following ways. Practitioners and GP's – sorry, the GP's and specialists would provide services to the insured patients. The medical funders will reimburse the practitioners for the services provided. The medical funders has contract practitioners [] to preferred provider networks. What it means is that medical funders will go out to the markets and invite practitioners to

participate in networks. They agree on the terms and conditions of contracting and this is where you'd find that the funders will channel the patients to those providers that have been contracted through this process.

So, you'd find that – let's for argument's sake, if you own a particular benefit of the medical scheme, they will say "These are the doctors that are on our network. You can only go to these doctors. If you don't go to these doctors, then it can attract an out of pocket payment." So, the funder will not reimburse in full so you as the patient will then have to reimburse that remaining amount from your pocket. We've got also a GP [networks] where it's similar there's an overlap between preferred provider networks and these GP networks where generally GP's are invited to be part of the network and if they are part of the network, the funders will reimburse them in full.

And then you've got direct contact where you know, the price is determined at an individual level and this happens largely where you have specialists that have some level of market power.

CHAIRPERSON 1: Can I just ask you about the preferred provider networks? Now you've said the funders and the doctor's medical practitioners, would agree the terms of a contract. But my understanding is that there is really no negotiation. You apply to get into a network and when you get into the network, the terms are imposed by the scheme.

MS RAMOKGOPA: I was going to touch on that a little bit.

CHAIRPERSON 1: Oh I see, okay.

MS RAMOKGOPA: It depends on where the market power lies.

CHAIRPERSON 1: Yes, alright. You will still come to that.

MS RAMOKGOPA: Ja, I'll come to that, Chair.

CHAIRPERSON 1: Okay.

MS RAMOKGOPA: Thank you. So, lastly, the medical scheme benefit design influences how patients' channel, so how [] practitioners channel patients through the health care system. So, your benefit design will tell you either you go directly to a GP then the GP will refer you but some plans, you've got a leeway to access the health care system whichever way you choose as a consumer and it's largely your comprehensive plans that will you know, allow you that freedom. But largely, the low-cost plan system once they [] channel you into the health care system.

So, in terms of practitioner reimbursement models you've got fee for service. Fee for service is where the practitioner will charge based on each service that has been provided and then you've got fixed fees, global fees, capitation agreements those we call alternative investment models where a certain amount of a fee is agreed between the practitioner and the funder and usually those alternative investment models, they have some risk sharing arrangement between the practitioner and the funders.

And the extent to which these reimbursement models are applied are subject to the ethical rules of the HPCSA, for example

look, we know that the HPCSA in some instances prohibits the use of fixed fees, which we find to be pro-competitive [] in the sense that they minimise cost and the transfer is between practitioners and the funders.

And then funders use practice code numbering to verify and pay the practitioners and also, the prescribed minimum benefit regulations, which is like mandatory cover for prescribed minimum benefits that are payable at cost. So, with this, we will touch on the question that Chair asked. So, tariff determination [].

Historically, tariffs were set collectively between practitioner association and the funder association. So, at that time, I think the practitioners were represented by SAMMA and their funders were represented by the BHF.

We added this practice in 2003 since we found the conduct [] to be anti-competitive [] and to be collusive. So, since then practitioners have determined tariffs in one of these four ways. So, you have medical scheme administrators or a scheme determining the fees that we need to pay the practitioners. So, in this instance, a funder would say, “These are my figures. This is how much we’ll charge my patient.”

Alternatively you have a group of practitioner groupings, who would then group themselves and approach the funders and negotiate the fees. Or, you would have the practitioners grouping simply publishing the tariff guideline that the medical schemes will reimburse, or you have a practitioner that may determine fees that

they are willing to charge patients individually. The above are determined by the market power that lies on each side. So, what we are finding is that the GP's in particular are price takers [].

They don't have much bargaining power against the funders so they will be the ones that just simply take the price that is imposed by the medical schemes.

So, if we have to talk about the preferred provider networks, this is where the GP's will be told, these are the terms and conditions of contracting and simply, because they don't have the bargaining power, they will accept the conditions that are imposed by the schemes.

CHAIRPERSON 1: And do you find this in respect of GP's across the country or GP's located in specific geographic regions?

MS RAMOKGOPA: The dynamics differ. So, where you find GP's in locations where there is no competition, it gives them some level of bargaining power or market power. So, in such instances, you find that GP's might be able to negotiate prices. But where you have GP's that are largely concentrated or where you have a lot of GP's, there is a number of them, the bargaining power is relative weak, and this is where they become price takers.

And I think because our prohibition of collective arrangements, some GP's do not organise themselves to be able to increase [thier] negotiating power. Hence, they become price takers.

CHAIRPERSON 1: Yes. I mean, when you talk about the price, what exactly does that mean? Because I've asked another witness, it looks like when you talk about the price, we're talking really about three things. A price decided by the scheme, which has its own tariff and then a price decided by a doctor to the patient. And then there's another price which is called the reference price which is determined by the government.

MS RAMOKGOPA: The reference price in my…in our view currently doesn't necessarily exist. There used to be a reference price after, after hour prohibition of collective bargaining. There was a process between CMS, the Department of Health and I think the Competition Commission was involved at some level, where a reference price was published but there were legal problems with the reference price list that was then taken to court and overturned by the court. So, that reference price list it's in theory there but some practitioners use it, some practitioners don't use it. It doesn't really have any legal standing as I understand.

So, you find that other practitioners still refer to it. Others don't refer to that. As I say, some of these issues are determined by the market power and where the bargaining power lies. You've got practitioner associations who are able to group themselves and determine reference prices. So, you can have a group of paediatricians, grouping themselves and developing their own tariff guideline. But at the same time, you can have medical schemes

saying, “This is my price. These are my prices” and they impose those prices to the practitioners.

CHAIRPERSON 1: Yes, now I’m going to try to understand your, as I understand your broad point here is that general practitioners are vulnerable to the market power by schemes and so schemes impose a price, what price are schemes imposing?

MS RAMOKGOPA: Is the prices that would have been determined by the schemes.

CHAIRPERSON 1: It’s the tariff between the scheme and the doctor?

MS RAMOKGOPA: The scheme would have determined the price and then when they go out to the market to contract the GP’s, they will, “This is the price list.” They will explain, I believe their rationale for the price and then this is what the GP’s would have to charge.

CHAIRPERSON 1: Yes. You see because that’s the one price but there is another price between the GP and their own patient.

MS RAMASOLO: I believe that that price between the GP and patient must be guided by what the scheme is willing to pay. If the GP or the practitioner believes that that price that the scheme, will pay, is not sufficient, they might charge the consumer the co-payment []. So, this is where the consumer will have to now on top of what the scheme would have paid, they will have top up with their own amount.

CHAIRPERSON 1: And what were you finding in your investigation that GP's generally charge the exact amount that is decided by the scheme because the population that they service in any event doesn't have the ability to make the upward co-payment []?

MS RAMOKGOPA: I mean, we didn't find a lot of deviation by the doctors from the amount that's being charged.

CHAIRPERSON 1: Ja.

MS RAMOKGOPA: Or that's been imposed by the schemes. But we do know of unreported levels of out of pocket payments and nobody has been able to properly estimate how much you know; some GP's might feel they need to charge over and above what the schemes would have reimbursed.

CHAIRPERSON 1: So, when you say you didn't a find a lot of deviations, you mean – so I just want to make sure I understand this clearly. These schemes have a lot of power especially over general practitioners. They impose the price; the general practitioners take the price and you don't observe a lot of deviations. In other words, as a matter of common practice doctors will charge precisely what the schemes want?

MS RAMOKGOPA: That's the main finding especially in relation to the GP's.

CHAIRPERSON 1: Ja.

ADV HASSIM Sorry, Ms Ramokgopa, would you answer to that be different in relation to specialists?

MS RAMOKGOPA: Slightly. It would be different, but we didn't go into really detail on this one. But we found that a service specialist market has market power and it's represented by the ability to unilaterally determine their own pricing and schemes would be forced to accept the prices that would have been determined by the specialists.

ADV HASSIM And how would they have that power that unilateral power? Would it be the nature of the specialisation or the area in which they practice? What would it be?

MS RAMOKGOPA: Ja, it will be based on a number of factors. It would be where they practice, or you find that there is only one specialist in a town. They compete with anyone so they are able to determine their own price that they will give to the medical schemes. There is also coordinated conduct [] which is what I've got in the – it's the third point there, where they group themselves and it's a group of specialists and they collude to say these are our prices and then the scheme will have take that price.

CHAIRPERSON 1: Can I also ask something related to how this market power manifests? So, the one is at the setting of the price. But there might be an argument that you've got an alternative you can charge your patients directly.

MS RAMOKGOPA: Well it depends. I mean you can only – you can charge a patient up to a certain point you know, especially if you going to be dealing with largely, patients from low income

backgrounds. There is a limit that you can charge. So, it depends. There is an extent to which that you can exercise that power.

CHAIRPERSON 1: So, even the idea that I mean because I want to understand what pressures the GP's are facing. So, the one is the schemes are too powerful. They decide. But you really do not have an alternative because the population that you are servicing simply cannot pay.

MS RAMOKGOPA: Ja, I think those are the dynamics.

ADV HASSIM : Sorry, just a question about the reference price list. It's not valid in law we know, anymore but it's sort of there, used in some way and if that the case, how has the reference price list been adjusted every year since it's been struck down?

MS RAMOKGOPA: So, our understanding is that the practitioners who use that some of them would just add inflation to what existed the previous years. Those that have market power they may even add multiples of inflation to that reference price list. Again, some collude and use that price list to say you know, these are our tariffs and the medical schemes will have to then accept that.

ADV HASSIM : So, it would be most open to manipulation by those who have market power?

MS RAMOKGOPA: Exactly.

ADV HASSIM : So, GP's for example wouldn't be able to really use multiples of inflation in order to adjust?

MS RAMOKGOPA: Yes and I think I'll get to this in the recommendations that this is one regulatory gap that we find that's contributing to this.

ADV HASSIM : Thank you.

MS RAMOKGOPA: Ja, I think I've already covered these three points. But I think one of the – also main things, you don't find GP's refusing to participate in provider or DSP arrangements. But definitely, some specialists do refuse to participate in those arrangements. So tariff determination is also linked to clinical coding. So, coding is linked to tariffs in order to come up with a tariff especially in a fee for service environment. Each activity performed by a practitioner has to be labelled and this process is called coding.

It translates medical information of patient's interaction with health care providers into alpha numeric codes. It provides a form of stand communication that identifies which procedures, diagnosis or services have been delivered. So, codes form the basis in which tariffs are determined.

ADV WILLIAMS: Ms Ramokgopa can I interrupt there. Could you just explain and excuse my ignorance, but what is a alpha numeric code?

MS RAMOKGOPA: So, these are – they are typically called [ICD 10 codes] codes in the market. So, you go to a doctor, he diagnoses you with a particular condition. That condition will be then classified in terms of the code. So, it helps the funders as well,

identify the services provided and then also reimburse the service provider.

ADV WILLIAMS: So, it's definitely a diagnostic code.

MS RAMOKGOPA: It's a diagnostic code, yes.

ADV WILLIAMS: Okay and then how does that translate into determining your tariff because obviously what, let's just assume someone is using a variant of the RPL or the NHRPL. There's a description in there as to a procedure performed. Is there any correlation between what the ICD10 code says about diagnosis and what the reference price list or the NHRPL says about the service performed?

MS RAMOKGOPA: I am not sure about that.

ADV WILLIAMS: No?

MS RAMOKGOPA: But there is a link. So, I think the tariff guides or the tariff, the RPL, the reference list right, would be based on the ICD10 codes or the diagnostic codes. So, it informs what services would be provided and how much would be paid [indistinct] by their funders. I hope I've answered that clearly.

FEMALE SPEAKER: Okay.

MS RAMOKGOPA: And then you've got interaction between health care facilities and practitioners. So, practitioners refer patients on an in-patient or out-patient basis to health care facilities. Medical funders would then reimburse both the practitioners and facilities in separate accounts. Practitioners have various relationships and contracts with facilities as I mentioned earlier so

they lease, rent or rent a practice room from facilities. They have shareholding in health facilities and there anything else also other financial incentives between practitioners and the facilities.

All of these are subject to the ethical rules of the HPCSA. In terms of the competition dynamics from the interactions that we've just outlined, these are the ones that serve to create an imbalance in practitioner relationships with patients and their funders. So, between patient and the practitioners there is what we call information asymmetry. What it means is that largely the consumer doesn't know the services that they are providing, so they're already at a disadvantage because they are even unable to negotiate the price or to be able to inform the services that they, they are purchasing.

Also you have moral hazards where you find that patients because they are covered by a medical aid, they will unnecessarily require care and doctors may be over cautious in some instances and also over treat when it's not necessary to over treat. In South Africa, in particular we find that this fragmentation of care where you have practitioners operating in silos. There is no integrated care where you find that you will have primary care practitioners, they are linked to specialists and facilities and products are being provided in an integrated way. So, everybody does things on their own and it results in a lot of wastage in the markets.

In terms of regulatory failures, the key problem in the South Africa market is a lack of supply site regulator. The supply site

regulator being the regulator the [indistinct], the health care practitioners and the facilities. One might argue that the HPCSA exists to regulate the practitioners but there are many regulatory gaps in the HPCSA mandates.

One of the key things that we find is that post our intervention in 2004, we'd hoped that the sector would develop some tariff determination process and guidelines for practitioners. And this would alleviate the problem where there is market power dynamics between the funders and the practitioners or a market power dynamic between specialists and the funders. So, it is important that some tariff guideline be determined but this cannot be determined by the market. It has to be a regulated process.

We will also find that there is persistence of fee for service tariff determination where there is no strict sharing models between funders. We prefer bundled or alternative reimbursement [indistinct] models that are generally cost effective and the transfer is between the interacting parties. The PMB regime that requires reimbursements at cost for all the service providers, provided it is certified as a [indistinct] over utilization of services particularly hospi-centric services. Even the benefit design [indistinct] the way it's structured, it incentivises [indistinct] over utilization.

There is also a lack of outcomes and quality reporting by practitioners even facilities for that matter. So, one of the key recommendations that we want to say is that there must be some level of outcomes and quality reporting and practitioners are able to

use that for peer review to see where there is unnecessarily wastage and cost. Even the funders are able to monitor properly what is happening in their provider market. Currently, funders have their own systems of assessing quality or outcomes or examining whether there's fraud or wastage. But the process is not [indistinct] transparent. It happens largely within the funding market and in some instances, it's seen as a competitive advantage to certain funders, whereas if the process was public, everybody could be able to assess exactly what the funders see as wastage, as fraud and maybe unnecessary utilization.

And the other regulatory [indistinct] that we find is that the ethical rules, they are outdated. They don't promote a sort of novel [indistinct] and innovative models of care and this is one of the reasons that we find that there is higher utilization in the markets. The incentive structures and exclusionary practices – there are shareholding in these agreements that – and other financial incentives that we find are exclusionary particularly towards historically disadvantaged practitioners and new entrants. The large number of contracts that we reviewed our shareholding contracts or lease contracts, we find them to very exclusive and it operates on the other side as well.

So, new hospitals that want to enter the market, they also struggle to attract practitioners because practitioners are bound by these shareholding and lease agreements, which are largely exclusive.

ADV WILLIAMS: Can you expand a little more on what you mean by exclusive?

MS RAMOKGOPA: So, you would find a lease agreement which says that a practitioner can only operate in this facility and cannot operate in other facilities that are within a particular radius of that facility. Also, you find that there are long [indistinct] between the facilities and some practitioners such that new practitioners that have just qualified, they struggle to access those facilities.

CHAIRPERSON 1: In what way are they racially exclusionary?

MR BONAKELE: Chair, we have earlier indicated. We have not really done a deep analysis of that but there is a correlation often between race and entry because the incumbents tend to be white. And as I have – we will submit to you in the end, the types of complaints we have received indicate this. Because we get a lot of complaints from practitioners who want to access facilities, and these will tend to be new entrants and they would largely tend to be black entrants.

CHAIRPERSON 1: Thank you.

MS RAMOKGOPA: And then also the practice numbering system we find that as well, it's inefficient and it's exclusionary. There are practitioners that approached us to say that they struggle to get especially the new entrants, they struggle to be allocated a practice number and if you don't have a practice number you cannot be – you may not be reimbursed. And then the coding again, a

regulatory failure in the sense that this is generally when you look at international markets, government responsibility, so we don't have a structured coding system that can be used across the board. Instead a practitioner grouping such as SAMMA would then develop a coding system that may not be accessible to all the practitioners in the markets.

ADV WILLIAMS: May I just ask you to expand on that, so this issue of coding because it's some concern in relation to the issues that are arising in this. Let me think how to phrase the question. Two parts to the question, how many coding systems are there at play, do you know? And is there such a thing as the correct code to describe let's say treatment for want of a better word? And if you don't know the answers it's fine, just asking the question.

MS RAMOKGOPA: Okay. No, that's fine. We don't know how many there are but we know there are numerous in the market that are being by various practitioner groupings]. And based on international practice this would be determined by maybe government in consultation with stakeholders and there will be a standard coding list that is used by all the practitioners. And through interactions the market change, it may be updated but it's in consultation with all the industry [indistinct] stakeholders but government or the departments will the custodian of the codes.

ADV WILLIAMS: So, you're talking about the ideal the …?

MS RAMOKGOPA: This is the ideal which we don't have in South Africa.

ADV WILLIAMS: So, the practical reality is numerous both claimants [indistinct] by let's say private and public sector entities.

MS RAMOKGOPA: Ja.

ADV WILLIAMS: And sorry, my second question which was is there such a thing as the correct code to describe a particular service or treatment?

MS RAMOKGOPA: I am not sure about that, but I do believe that maybe through an industry engagement an acceptable code can be determined.

ADV WILLIAMS And the ICD 10 codes, isn't that a code that is most in use by most practitioners [indistinct] there might be, isn't that the default, if I might call it that?

MS RAMOKGOPA: Yes, you are correct. The ICD 10 codes are the default. Ja, so as I mentioned most of these dynamics impact on new smaller entrants and we find that most of them will tend to be historically disadvantaged practitioners, they struggle to access the market.

So, one of our key findings in the provisional findings report was over utilization which sometimes may be seen as fraud in the market and we raised concerns that the funders in particular are not managing the over utilization of health care services properly and in the interest of the consumer. So, we've seen recent developments by the funders to try and manage over utilization and we welcome this initiative. However, there must be a balance between managing over utilization and exclusion of smaller entrants and who

might not be as sophisticated and are still trying to penetrate the market. So, there must be a balance. And generally, we believe that some of the dynamics are simply because of some of the structural problems that we have because of the regulatory gaps and these may be addressed by some of the [indistinct] reforms that we propose to drive and drive down costs and curb over utilization and fraud.

So, these are our proposed interventions and they largely affect the practitioner markets. There are other ones, but these are targeted at the practitioner markets. So, we proposed an urgent review of the HPCSA rules to enable an integrated and new innovative models of care to allow for global fees and alternative investment [] models and improved monitoring of contracts and incentives between practitioners and facilities. I think this is important in the content of exclusion that I spoke about. We found that the HPCSA really doesn't monitor the contracts that exist in the markets between some of the incumbent hospitals and the practitioners and some of these contracts are long-standing [indistinct] but they have never been reviewed by the HPCSA and understandably so maybe because they don't have any legal or regulatory authority over the facility markets.

So, a review of these rules to enable that monitoring will be important. Tariff determination framework, we need to start moving away from free for service and have a reference price list with maximum price for prescribed minimum benefits implemented.

This needs to be done through a public process managed by a regulator. We need to have a review of the coding. We also propose a review of the PMB regulations. We understand that the process is already under way and also, a standard benefit design that will re-define the health care pathway, promote primary and preventative care and again, we emphasise the important role of the GP, which is lacking in South Africa. The GP should be the gatekeeper to the health care system.

We recommend outcomes reporting. This is where we can have a system of collecting quality indicators auditing and reporting. It enables peer review. It will curb overuse and fraud. If we are a group of practitioners and we see that other practitioners in Limpopo are practicing in this way and it's leading to good outcomes, we are able to reflect on that.

The practice numbering system, we propose that it be reviewed and primarily it be removed from the mandate of the BHF. It should be a regulatory process, and this should ensure that there is no exclusion embedded in the process. Thank you, Chair.

MR BONAKELE: Chair, if I may just now start concluding. As my colleague has indicated, we are recommending many structural reforms to promote access and entry into the market. We think that this is more of a problem of a system and we would recommend a systematic approach to its resolution. We understand there may be individual instances where you may want to indwell into the specifics of that individual case but from a – our point of view, we

think that there are ways in which one can develop a system that ensures that the new entrants are able to get into the sector and access critical facilities. And we think that crucial to this is the establishment of a supply side regulator, that should be empowered to deal with these issues of access and indeed, the other moral hazard of over utilization because, one has to be careful to strike a balance between protecting practitioners, but also protecting patients, whom we have indicated are often the weakest link in the chain because of information passing it.

We have also accepted, I hope we have made it clear that we accept that GP's in particular, amongst those who are kind of bargaining in the value chain because the patient doesn't even bargain, but at least, amongst those who have a potential to bargain, the GP is probably the weakest and so, whatever system is designed, I think we'll have to take into account their position in the market, which is that of a price taker. We think that, as we have indicated, crucial to this must be a transparent way of measuring performance outcomes and quality, so that you don't have practitioners who are successful not because of merit but because they are either incumbents or are favoured [], as a result of all these relationships we have outlined that cause some perverse incentive. So, I think, one can introduce some meritocracy [] in the system.

I think the last thing we've said is that also, the issue of risk sharing between funders and practitioners is quite important as right

now, funders blame [] assume no responsibility at all for the outcomes. We think that this would be necessary to achieve the universal health coverage. And then lastly, Chair, what we have done is, we have provided just a list of complaints we have received over the years from 2015. I will just not mention these here, because I don't know if the complainants would be comfortable and we have not consulted them. But, just to illustrate the gravitas of the problem, from 2015 to now 2019, years [], we have seen then an increase in the number of complaints by 244%. 2015 we recorded 9%. This is now amongst all the complaints we received at the commission. The following year we received, in the 2016 - 2017 year, we received 12 complaints. 2017 - 2018, we received 17 complaints. 2018 - 2019, we received 31 complaints. So, they are clearly increasing, and they typically would be about exclusionary agreements between private hospitals and service providers. There are a lot of, a number of complaints from health care service providers, who provide things like renal and pathology services, who allege this exclusionary act. We've had people for an example, who want to provide even optometry and other services, who are not able to locate at the hospitals. We have also received some complaints about the DSP arrangements, who feel, providers, who feel that they have been unfairly excluded as a result of these contracts. We have, as I have indicated, tabulated all of these and we have given you the names. I think, if you are inclined to utilise them, we can check if the complainants would be comfortable with their names

appearing in public reports. Thank you very much, Chair. That is it from our side.

ADV HASSIM : It's a question for Ms Ramokgopa and it's about the tariffs again. In the report, there is reference to Healthman Consulting, who was commissioned to prepare some tariff guidelines. And then there was a complaint that was brought by BHF to the commission. I just wanted to know, one, what was the outcome of the complaint and two, what is your understanding of the role that Healthman Consulting played? Meaning, was there any benefit to having those guidelines and should they be continued?

MS RAMOKGOPA: So we investigated the Healthman complaint. That was just before the commencement of the inquiry and we had non-referred the complaint, not on the basis that there was any - there was no wrongdoing, but we wanted to look at all the structural issues around price determination at the health care market. Our understanding is that Healthman is a consultant that collects cost information on behalf of practitioners and, on the basis of that, advises the practitioners what prices they can charge, or assist them with their tariff determination. And preliminary, we thought that a conduct [indistinct] is anti-competitive, but it was important to locate.

ADV HASSIM As anti-competitive.

MS RAMOKGOPA: Anti-competitive. It was important to locate the conduct within the context of the lack of mandatory or sort of a

regulated tariff list, and practitioners then resort to this kind of conduct because there is nothing that guides them, in terms of tariff determination. So, although it might be anti-competitive, but it must be located within the broader context of price determination and the lack of a proper tariff guideline in the market.

CHAIRPERSON 1: Thank you. Mr Commissioner, I just wanted to ask you on that, so if we take your position seriously that the problem is a structural one and if we had to approach it we need the systemic intervention, and yet, the problem that you have identified is over consideration of power on the part of schemes and lack of market power on the part of general practitioners, who are individual, isolated and often find themselves vulnerable and exposed. But they are not able to organise in order to bargain for a better relationship with the schemes. What is the structural intervention necessary to regulate that relationship?

MR BONAKELE: Chair, maybe I'll start with the acceptance on the part of the commission that the intervention we made did serve to weaken those who are weaker in the system. So, the bargaining was useful as far as you had a lot of GP's who are scattered, than say it was useful for facilities who also are concentrated or funders who also are largely concentrated. So, we accept that the regulator will have to step in to re-balance that. Now you may accept that it's a contravention of competition law as it is currently framed, but it doesn't mean that you don't recognise the problem. I think we recognise the problem that the GP's do

need to be strengthened in the system. And that may include, for an example, allowing them to bargain together through some form of a legislative intervention or some other regulatory intervention, or, as we have indicated, a tariff that is prescribed by an independent body that would obviate the need for the bargaining process.

So, those options are there. I think that the one-size-fits-all intervention of competition law is not helpful in a sector like this because it does lead to inequitable outcomes and that we have accepted. But, there is a caution, as I have indicated earlier, which is that of protecting the patient as well as you do that, because, as you strengthen the doctor, you need to recognise that the patient may also be ultimately be the one that is exploited. So, I think one needs to be very careful about whatever system that is introduced, if it's a tariff, it's got to have independent people for an example, who are involved in the determination of the tariff, rather than just have doctors themselves alone, making that determination. If it's a bargaining, you also need to have a system of safeguarding the doctors who may be strengthened but could also simply be captured by the funders.

There is a history sometimes of those who are weak being strengthened, only to identify a commonality of interest with those who are stronger. Certainly, these are some of the arguments that have been used with the funders when they bargain or when they used to bargain with the hospital groups that, instead of the funders playing the role of bargaining on behalf of the insured patients that

they could have identified a commonality of interest between themselves and the hospital groups.

So that is also not unthinkable in the case of doctors but, I think that one would have to think very carefully and we think that the starting point is perhaps an acceptance that there needs to be a regulator, a supply side regulator that will consider all of these things that would conduct research, that would lead into evidence based interventions.

CHAIRPERSON 1: One of the things we heard earlier, we had a number of medical practitioners who are part of Solutionist Thinkers, is a concern about information sharing, that the schemes share information around medical practitioners that are perceived to be outliers and that is a problem. I mean their perception is that, that itself [indistinct] racially loaded. I don't know if it is or is not. But I wonder if there are no other competition concerns relating to information sharing among the schemes.

MR BONAKELE: Chair, I - the schemes are very concentrated, so I do wonder whether that, for us, is a significant concern. For an example, if you just look at Discovery, it doesn't need to share information with anybody for it to exercise market power. So maybe if that is a concern at all it may apply to smaller schemes, but we are more concerned with market power and the concentrate- - just the mere concentration there, suggests that everything else is less important. You have, you already have a person who doesn't need to share information with anybody, who

can exploit that power and that's perhaps why you need - you need a regulator.

ADV HASSIM I would like to ask you about your recommendations in relation to the funders and I just wanted to know if you could expand a little bit on the relationship between schemes and administrators. We know that there – we've seen what you have presented about the market share that schemes have as a grouping and administrators as their own grouping, but there is something, but there's an important relationship between the schemes and the administrators and I just wanted to pick out a few things which I'd like you to address us on if you are able to. Well we know who the big players are so let's not go there.

One of the things that, one of the findings was that a failure of governance that aligns scheme interests too closely with that of administrators, that was something that was a cause for concern. If you could address that in a little bit more detail. Secondly, related to that of course is the capacity of administrators versus schemes, analytical capacity, investigative capacity, whatever it is. So that relationship between schemes and administrators is something I am trying to probe with you and then finally this which I am going to quote from the Competition Commission's – well, the panel's provisional report is the following:

"We find no evidence that schemes demand information on the costs saved by administrators related to for

example, managed care or fraud control and whether the related savings are passed on to scheme members.''

So we know that the responsibility for managing fraud and waste is with administrators, but this suggests that the schemes are not demanding something from the administrators which they ought to be demanding, which is that the savings are passed on to the schemes. Am I understanding that correctly and if I am wrong please feel free to say so?

MS RAMOKGOPA: Just a minor disclaimer. Those were the provisional findings and we engaged with stakeholders and at a final position on these issues will be in the final reports. But I think your understanding is correct; we didn't find that the schemes in particular the trustees their efforts were aligned to the interests of the consumer and we found that there were no mechanisms particularly from the regulatory side that will force the schemes and the trustees to act in the best interest of the consumers. So just a simple example around bargaining, you don't see schemes going out and say, "We we want to bargain at a price less inflation" so the target is always, you know above inflation you don't see that effort to drive costs down. You don't see effort to manage utilization and the responsibility as a step [indistinct], the administrators really can just go into the market and bargain, not really protecting the interests of the scheme, of the consumers. And it is simply because they are no accountability mechanisms between the administrators and the schemes that are enforced by the law. Administrators have

no accountability towards the members of the schemes. Hence, but they go out and negotiate for the patients, so those are some of the governance issues that we have picked up and then we've made recommendations that some of these governance issues must be addressed.

Even in terms of the evidence from the managed care organizations that exist in the market. We don't see outcomes of those managed care arrangements, they are not transparent, they are not published to - I mean we understand that there is some reporting that is done to the Council of Medical Schemes but the process doesn't seem to be transparent that we feel that the interest of the consumer is protected by those arrangements. So your understanding is correct and the final position that the panel would be reflected in their, in their final report.

CHAIRPERSON 1: I mean what does that actually mean in practice? So if there's - as I understand the theory that you coming with, it is that look we say as the commission there is over utilization and there's fraud and that's ultimately harmful to consumers, right. So, that's first [promise] and then you say well then you have a duty to make sure you sort out under utilization - over utilization and then you sort out fraud and that is what the schemes are claiming to be doing but what is coming out is that even though the schemes recover some money as a result of over utilization and fraud, no-one knows what happens with that money.

MS RAMOKGOPA: Yes, so there is no transparent process where there benefits of those [] you know can be interrogated by the broader public and even in terms of the costs, you don't see that passed down to the consumer and we didn't find proper evidence of this but we suspect that it's because of the complex relationship between the administrators and the – and the schemes. But I think also we need to distinguish between over utilization, over servicing and frank fraud, I mean I think there is frank fraud that is something else to what we investigated; we looked at over utilization.

CHAIRPERSON 1: Yes but I mean, you would say on both, if you recover from over utilization and you recover from fraud, there must still be a benefit to the members and that's the problem you say you have identified.

MS RAMOKGOPA: Yes, I mean you don't even see it in terms of reduced premiums, the premiums keep on increasing every month. So all the savings we don't see them being passed on to the consumer.

MR BONAKELE: If I may with your permission Chair the issue of utilization has to be addressed through incentives. It should not be there at all, if the – if the incentives are correct. So that is another systemic issue, I mean I don't know about fraud, I think you know, fraud is a little bit harder when you have people who just break the law. I don't know if you will ever be able to eliminate that completely but it seems to ask that – we should at

least change the incentives for over utilization and I think the report is quite clear that South Africa is really an outlier when it comes to this.

So even if there, we don't eliminate it completely but just bringing us down to the level where everybody else is at, will make a huge difference. So, it seems again, there we have a systemic problem and as my colleague suggests, the part of this could be just the design of the – of the relationship between administrators and schemes. This is a typical case where the policy and outcomes are not – are not in sync because they - it was never envisaged that the administrators would be so powerful in the system and that the schemes would be so weak because it was all premised on people participation - participating in schemes, meetings and holding administrators accountable. But we now know that that system has not worked at all and we need to introduce something else in the system to correct for that problem.

ADV WILLIAMS May I just ask a point of clarity just so that I understand kind of the full weight of your submission? Am I correct to summarize as part of the submission is that the Commission views the cost sayings that come from administrators and managed health care's methods to tackle fraud, waste and abuse, so then, sorry, the Commission reviews the cost savings as not bringing consumer benefit because it isn't leading to prices going down in the market?

MS RAMOKGOPA: Correct, we don't see any evidence of that.

ADV WILLIAMS And just for fullness of debates, I imagine the schemes and the administrators at some point will make submissions on this and will argue that there is a benefit in terms or premiums not going up more than they already are, how would you respond to that?

MS RAMOKGOPA: I think our submission is that the fact that the process is not transparent it's very difficult to interrogate whether premiums would have gone up or being lessened if there was a mechanism where the costs, the savings and are fully available, it will be easy to interrogate that. But at this point with the information that we received; we didn't see any benefit.

CHAIRPERSON 1: Right. Thank you, I believe that will be all from the panel. Mr Commissioner, it remains for me to thank you and your team for coming and presenting. Your presentation will no doubt enrich the work of the panel. I presume that your slides have been shared with the secretariat. I see somebody nodding, so that's - probably means yes.

ADV HASSIM But this side is nodding, and that side is shaking their heads.

MR BONAKELE: But it is available, Chair, if it has not been made available, we certainly will make it available together with the list of complaints.

CHAIRPERSON 1: With the list of complaints, yes. Alright, thank you very much. That will be the end of today, we should commence again tomorrow at 10 o'clock hopefully, promptly, I can't remember who's presenting tomorrow. Okay, CMS.

5

CHAIRPERSON 1: Alright I am sure CMS will keep to the time. Alright thank you, we are adjourned for the day.

PROCEEDINGS ADJOURN

END OF AUDIO