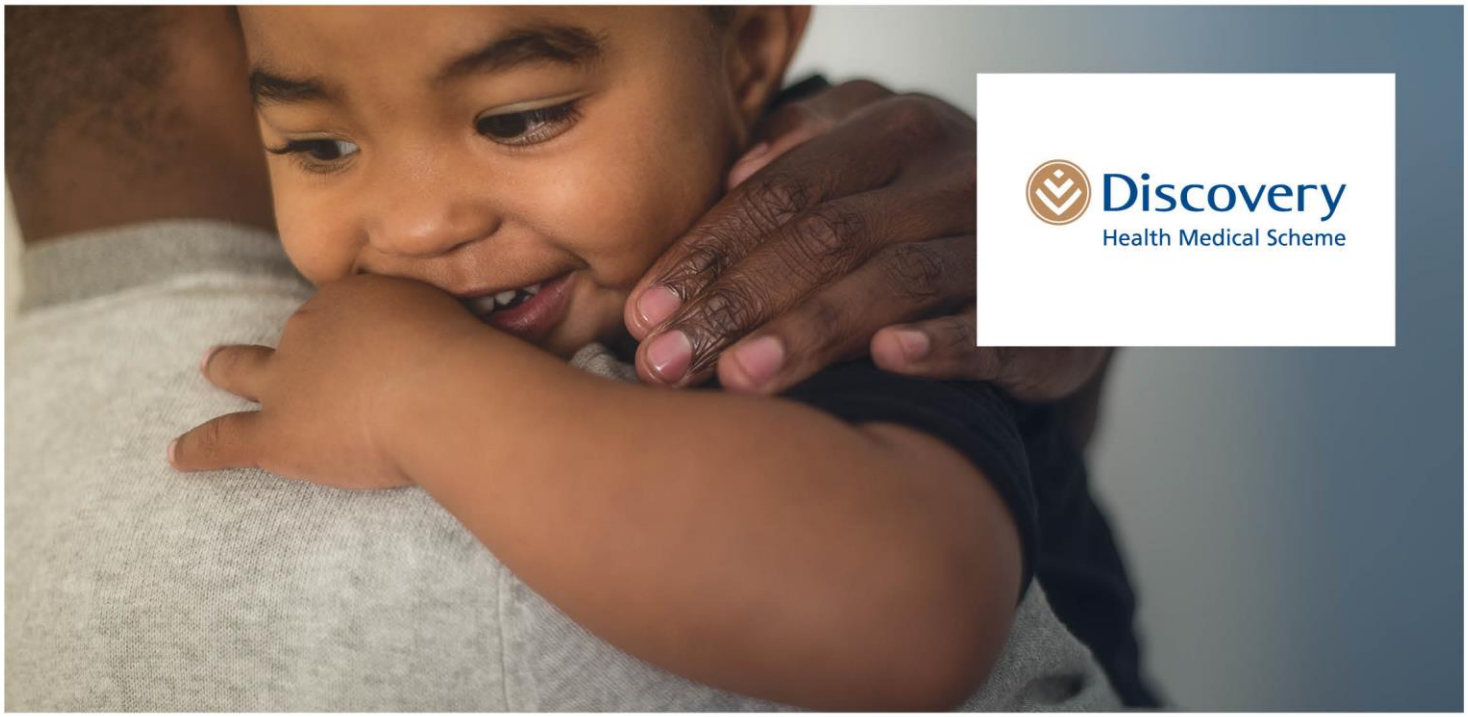

Discovery Health Medical Scheme
Response to the HMI Provisional Report

15 October 2018

Contents

List of abbreviations

ATB	Above Threshold Benefit
ARM(s)	Alternative Reimbursement Mechanism(s)
CPI	Consumer Price Index
Deloitte	Deloitte & Touche South Africa
Deloitte reports	A set of reports on the state of the Scheme's transactional and relational governance based on a review conducted by Deloitte, at the request of the DHMS Trustees, in 2013 and updated in 2018. The work done by Deloitte for the Scheme also included a benchmarking of DHMS against its peers in the South African market.
DH	Discovery Health (Pty) Ltd
DHMS / the Scheme	Discovery Health Medical Scheme
FAIS	Financial Advisory and Intermediary Services Act
FFS	Fee For Service
FIPF	Financial Institution Protection of Funds Act 28 of 2001
GCI	Gross Contribution Income
HMI	Competition Commission Health Market Inquiry
HPCSA	Health Professions Council of South Africa
HQA	Health Quality Assessment
IoDSA	Institute of Directors in Southern Africa
MSA	Medical Savings Account
MS Act	Medical Schemes Act no. 131 of 1998, as amended
MSAAB	Medical Schemes Act Amendment Bill
NDoH	National Department of Health
NHE	Non-healthcare Expenses
NHIB	National Health Insurance Draft Bill
OMRO	Outcome Measurement and Reporting Organisation
PMBs	Prescribed Minimum Benefits
Report	The Provisional Report of the HMI
RAM	Risk Adjustment Mechanism
SAHPRA	South African Health Products Regulatory Authority
SSRH	Supply Side Regulator for Health

Value Added Assessment	A methodology based on publicly available information to quantify the value received by DHMS from DH in Rand terms, originally developed by Deloitte and reviewed annually by Deloitte.
Vested®	The outsourcing model that governs the contractual relationship between DHMS and DH.

1. Introduction

1.1 Discovery Health Medical Scheme (DHMS/ the Scheme) acknowledges the Health Market Inquiry's Provisional Report (HMI/ Report) and is grateful for the opportunity to comment on it. Further, as will appear from the comments below, DHMS supports many of the recommendations in the Report. The implementation of many of the suggested reforms would, in the Scheme's view, lead to a much better functioning market to the benefit of consumers in terms of both cost, access and very importantly, quality of care for better health outcomes.

1.2 DHMS further appreciates the extension granted to it for this submission which has been very helpful, given the volume of work the Scheme was concurrently occupied with.

1.3 While drafting this submission, we were also engaged in reviewing and drafting a response to the draft Medical Schemes Act Amendment Bill ("MSAAB") and National Health Insurance Draft Bill ("NHIB"), which are to be understood as "twinned" Bills. We believe that there is much in the HMI's Report that could change the industry in beneficial ways, and we hope therefore that the National Department of Health ("NDoH") will in addition pay close attention to the recommendations made therein and that there might be discussion and collaboration between the Competition Commission and the NDoH in the development of its final Bills. We therefore make mention throughout this submission of areas where we believe there is some overlap and common concerns to be considered.

1.4 We note the overall context presented by the HMI of market failures in the private healthcare industry. We concur that there are many challenges in the functioning of the market and welcome the relief provided by many of the HMI's recommendations. We believe that these failures are largely due to the incomplete regulatory environment within which the industry operates, as detailed in our previous submissions[1] to the HMI.

1.5 Due to the broad scope and extent of the Provisional Report and the HMI's investigation, in this submission we respond to matters raised by the HMI where we believe there is significant impact on the Scheme and its members but do not attempt to address all of the issues raised in the Report. In the first section of this document we respond to general statements made and views expressed by the HMI in the body of the Report, and in the second section we respond to specific recommendations made by the HMI. Where relevant, we note the related previous submissions to the HMI that have been made.

[1] DHMS and DH Comments on HMI discussion document on the need for and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition, 19 January 2018; presentation by Emile Stipp at the related seminar held on 01 February 2018.

Part I: Responses to comments and statements made by the HMI

2. The HMI's views on funders

In its Report the HMI gives a summary of its views regarding funders.

Failures of funders

The HMI comments that problems relating to the failure of funders with regards to consumers include:

Scheme options and quality outcomes are not transparent to members. The average number of options per open scheme has increased; comparison of options is difficult for consumers and a lack of classification creates confusion.
Medical schemes have introduced the wide range of benefit options as a way to induce clients to self-select, based on their own perceived risk, which is often termed innovation. The range of options and lack of transparency to members facilitates scheme competition on demographics rather than value for money.

2.1 The Scheme concurs that benefit options are complex and, as previously submitted to the HMI[2], suggests that this reflects the need to cater for a population with widely differing healthcare and affordability needs as well as the complexity of the underlying environment, such as the lack of clarity regarding PMBs, the multiple treatments and practices available, billing practices and incomplete regulations. DHMS's multiple plan benefits are also designed to meet the widely varying medical needs and financial situations of over 1.7 million members. It is not due to any deliberate attempt by DHMS to obfuscate consumers. DHMS supports better industry-wide classification of plan options to allow consumers to better compare, and reiterates the vital role of brokers in supporting consumers to select cover appropriate to their needs. We provide further detail regarding the ways in which we communicate with members to assist them in understanding their benefit options in section 5.

Medical savings accounts increase this complexity as consumers do not always know whether the administrator paid their claims from their savings or the risk pool.
Selecting cover based on price may mean inadequate cover for sicker consumers.

2.2 The Scheme supports the role of brokers to assist consumers to make appropriate choices and to better understand medical savings accounts versus risk benefits. We make further comments on brokers below and have previously submitted to the HMI

[2] Presentation by Discovery Health to the HMI, 2 March 2016; Discovery Health Medical Scheme Response to the Revised Statement of Issues of the Competition Commission Market Inquiry into the Private Health Sector, 24 March 2016

regarding the benefits of MSAs for consumer choice and management of expenses. We also note that it is very difficult for consumers to accurately forecast their personal health needs, but that it is one of the strategic objectives of the Scheme to increase member engagement in their own health and healthcare, and believe that increased awareness of their own risks may also support members in their plan choices.

Healthcare costs and administration costs are increasing and benefit packages cover less care.

2.3 The Scheme prices its member contributions each year to break even, with a slight margin to cover unforeseen events such as a sudden increase in utilisation, maintain solvency requirements and to maintain the stability of the Scheme, in accordance with its social contract mandate.

2.4 The high increases in contribution inflation (above CPI) each year are due to increasing utilisation – which is largely driven by anti-selection and supply side factors as previously discussed with the HMI. These are exacerbated by the effect of the regulatory environment of open enrolment and community rating without mandatory membership.

2.5 In order to contain the contribution increases, benefit reductions (or unchanged benefit limits) are sometimes required to ensure contributions remain affordable. Contribution increases are also tightly monitored by the CMS, who annually prescribe acceptable increase margins. If utilisation is very high in a particular year, then benefit reductions may be required to ensure premium increases remain within margins prescribed by CMS. As a general rule, DHMS does whatever possible to maintain benefits and to avoid benefit cuts.

2.6 The Scheme also critically reviews its benefit packages each year and wherever possible enhances cover, especially where the Scheme's experience has shown it to be needed for health reasons. Benefit changes may at times also involve the addition of more stringent requirements for authorisation and similar elements to discourage over-utilisation, which is one of the ways in which supply-induced demand can be countered. At times, changes may also be made to align to international best practice and clinical standards which may be perceived by members as a reduction of benefits, when in fact such changes serve to protect the health of the member body as a whole. Benefit packages must therefore continually evolve in response to the environment, clinical practice and the needs of the member body, within constraints of affordability in a challenging economic climate.

2.7 The Deloitte reports[3] included a review of non-healthcare expenses across the benchmarked schemes, and conclude that over time, the Scheme's NHE, as a proportion of GCI, is decreasing.

[3] A set of reports on the state of the Scheme's transactional and relational governance based on a review conducted by Deloitte, at the request of the Trustees, in 2013 and updated in 2018. The work done by Deloitte for the Scheme also included a benchmarking of DHMS against its peers in the South African market.

The lack of ability of consumers to compare options and schemes means limited incentives for schemes to contract innovatively with providers.
There is limited innovation by schemes in provider reimbursement models, and funders have struggled to set up effective networks for specialists.

2.8 DHMS disagrees with these statements. The experience of the Scheme is that environmental pressures such as increased utilisation together with a drive to improve overall healthcare management and reduce fragmentation in the market are strong motivators for the Scheme to work particularly hard in this area. As the HMI has identified, regulatory barriers and archaic, inconsistently applied rules are the primary barrier to this sort of innovation, and we support the HMI's recommendation that the existing HPCSA rules be reviewed and amended to facilitate more effective models of healthcare.

2.9 Within these constraints we believe that, with our administrator Discovery Health, we have been successful at making use of more effective reimbursement models and at creating innovative and effective networks, including specialist and other networks, details regarding which have been previously submitted to the HMI[4] and which are commented on below. Hospital groups recognise DHMS's innovation in that regard. The Scheme will continue to drive delivery in this area as we firmly believe that new healthcare models are essential for optimised clinical management and better health outcomes for our members.

2.10 To this end, in 2017 the Scheme established an Innovation Committee to ensure continuing focus on innovation, the forming and function of which is detailed in the Scheme's contract with DH.

2.11 The 2018 Deloitte reports benchmarked DHMS and 12 other medical schemes selected for the review against 19 innovative categories. Deloitte concluded that: "A scheme is identified as a market leader if it offers at least 13 of the 19 innovative offerings. A scheme is defined as innovative if it is performing as a market leader, and offers additional services to members over and above typical medical aid offerings. DHMS offers 17 of the 19 innovation categories." Some of the most recent and highly successful programmes in this regard are HomeCare[5]; the Compassionate Care Benefit[6] and the Advanced Illness Benefit[7]. Investment and innovation in technology to encourage member engagement with the Scheme and their own care is also taking

[4] Discovery Health Medical Scheme Competition Commission Submission: Private Healthcare Market Inquiry, November 2014; Discovery Health Submission Competition Commission market inquiry into the private health sector, November 2014

[5] Discovery HomeCare is a unique home based service that offers quality care in the comfort of a member's home. Cover includes postnatal care, end of life care, IV infusions and wound care. These services are paid from the hospital benefit, subject to approval.

[6] The Compassionate Care Benefit provides access to holistic home-based end of life care.

[7] The Advanced Illness Benefit provides comprehensive palliative care at home for members with cancer.

place, as demonstrated by the Discovery App[8], AskDiscovery[9], the MyPregnancy App[10] and the Discovery DrConnect facility.[11].

2.12 In addition, in its 2018 reports Deloitte confirms that "Network management is outsourced to DH. DH is therefore managing the contracting and maintaining of various networks including specialist network, hospital networks etc. This network management function also includes innovative contracting with providers".

2.13 With specific reference to ARM contracting with specialists, DHMS acknowledges the challenges inherent in the current South African healthcare industry resulting in difficulties contracting with specialists in general, in particular the relative scarcity of specialist skills across the country and especially sub-specialty disciplines, which results in a supply-demand mismatch compromising the Schemes' negotiating abilities (where specialists tend to be price-setters and the schemes price-takers), exacerbated by the HPCSA's ethical rules as noted above.

2.14 However, despite these challenges the Scheme, with Discovery Health as its administrator and managed care provider, has been successful in developing and maintaining specialist networks, through which negotiated tariffs are funded through Direct Payment Arrangements (DPA) according to the different benefit plans, mitigating co-payments to members. Furthermore, these DPA networks have gradually evolved in more recent years to Alternative Reimbursement Models, including global fee structures with hospital providers. Global fees have been more difficult to negotiate with providers, due to the HPCSA rules. Over the past several years, we have started contracting on the basis of value based care, which effectively shifts reimbursement based on outcomes including quality as defined and agreed by the parties to the agreement. In this regard, we have well established governance programmes with paediatricians, physicians and surgeons, and the latest including the joint arthroplasty network and the obstetric governance programmes. In addition, the Scheme has a number of capitation and risk-sharing contracts implemented through networks set up and managed by other accredited third-party managed care organizations, for example the Independent Clinical Oncology Network (ICON) for KeyCare options, and the Centre for Diabetes and Endocrinology (CDE) for Diabetes Disease Management for two of the Scheme options. The Scheme has recently implemented a value based multiplier to GP reimbursement to incentivise an improvement in efficiencies and outcomes.

2.15 The Scheme continues to invest in piloting new models of care, [redacted]

[8] The Discovery App is fully interactive, real time technology that helps members find doctors and hospitals, on their plan networks, near them. It allows a member to give a doctor consent to view their health records, assists in choosing a doctor that suits members' needs and allows members to book a follow-up video consultation with a doctor at the member's convenience.

[9] An artificial intelligence-powered chat facility that responds to member questions.

[10] The MyPregnancy app allows a pregnant mum to unlock additional benefits when pregnant and after the baby is born.

[11] Discovery DrConnect links members to healthcare providers and high-quality medical information. Please see the DHMS 2017 Integrated Report, available at https://www.discovery.co.za/medical-aid/annual-reports-and-financials, for more information on these programmes and DrConnect.

[redacted]

2.16 The Scheme leverages innovative information technology/digital tools to support these provider arrangements and value-based care, including clinical record keeping through the electronic health record (HealthID). Further the Scheme uses sophisticated analytical models to design the value based care initiatives.

2.17 DHMS also provides a wide range of network providers with over 2 500 pharmacies in the pharmacy network and a digital tool to allow members to find a network provider quickly and efficiently.

Schemes' responsibilities

The HMI states that schemes must take more responsibility for:

Ensuring that their administrators manage and contain moral hazard and supplier induced demand.

2.18 The Scheme agrees with this statement and ensures through contractual arrangements, regular monitoring by the Scheme Office and the Trustees, and investment in interventions to mitigate risk that Discovery Health puts measures into place in this regard. We can provide further information on this to the HMI if required. As mentioned elsewhere in this submission various environmental factors constrain the Scheme and Discovery Health in achieving these goals – for example the structure of the PMBs and the requirement that they be paid in full.

2.19 DHMS has previously submitted to the HMI concerning moral hazard as exacerbated by alternative healthcare insurance[12]; the insulation of consumers from healthcare costs[13] and provider behaviour[14] . Since providers do not bear any of the costs of treating patients, there is no incentive for them to restrain their provision of healthcare services and this may lead to over diagnosis, over servicing and coding diagnoses and procedures for more expensive services than are actually necessary ("upcoding"), which together with other aberrant billing behaviour including code unbundling and billing for services not rendered, contribute to fraud, waste and abuse ("FWA") of funds. Schemes and their administrators/managed care organisations do employ various systems and programmes to curb FWA, including

[12] Discovery Health Medical Scheme Response to the Revised Statement of Issues of the Competition Commission Market Inquiry into the Private Health Sector, 24 March 2016

[13] DHMS 2015 submission – limiting incentives for patients to search for low cost healthcare services, to limit the services they obtain and to take proactive steps to look after their own health. The use of medical savings accounts and other benefit design innovations such as GP to specialist referral processes and co-payments and deductibles for elective procedures, in-hospital scopes, prescribing certain non-generic medications and providing in-hospital dentistry.

[14] Discovery Health Medical Scheme Competition Commission Submission: Private Healthcare Market Inquiry, November 2014; DHMS and DH Submission to the Competition Commission Health Market Inquiry on Reports Published in December 2017)

through automated utilisation rules embedded in claims adjudication systems, retrospective claims auditing, and where fraud is suspected, forensics unit investigations through investigations undertaken by a dedicated forensics unit. These interventions have indeed been successful in curbing a significant proportion of fraud, waste and abuse, saving the Schemes a significant amount of money through recoveries and also the halo effect. A guidance note published by the HPCSA in August 2017[15] relating to prosecution of practitioners who are allegedly involved in fraudulent activities states that "In terms of Section 66(2) of the Medical Schemes Act, a practitioner registered under the Health Professions Act may not be prosecuted under the Medical Schemes Act as any act of unprofessional conduct by practitioners registered with the HPCSA is punishable under the Health Professions Act. Section 16 of the Medical Schemes Act places an obligation on Council for Medical Schemes to report cases of improper or disgraceful conduct (Unprofessional Conduct) to a medical scheme by practitioners registered with HPCSA to the HPCSA as the statutory body which has jurisdiction over practitioners registered under the Health Professions Act. Where a criminal offence has been committed, the Council for Medical Schemes is obliged to refer such a matter to the National Prosecuting Authority. The medical schemes cannot discipline or prosecute health practitioners for unprofessional conduct, but may report practitioners to the HPCSA for unprofessional conduct or report any criminal offence to the South African Police Service (SAPS")." It is our experience that in many instances where fraudulent behaviour is proven by our Forensics unit, and the guilty healthcare professional referred to HPCSA, the HPCSA has been hesitant or even done nothing to enforce relevant and appropriate sanctions, which we believe is important in setting precedent to mitigate the prevalent behaviours resulting in fraud, waste and abuse including through the halo effect. Hence we support the view that Scheme's efforts have to be supplemented by appropriate regulatory interventions and particularly with the support of and interventions by the HPCSA. We comment further on this in the section below titled "HPCSA rules revisions".

Developing and implementing effective ARMs; the HMI also expresses concerns regarding the effectiveness of ARMs due to carve outs.

2.20 ARMs are developed through intense and detailed negotiations with hospital groups and provider associations. The Scheme's view is that there are some valid circumstances in which carve outs are appropriate and acceptable in terms of the negotiation of risk sharing but the extent of current carve-outs does limit the extent of risk sharing at present.

15 http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/Announcements/ALLEGED_MEDICAL_AID_FRAUD_10_AUGUST_2017.pdf

Negotiating for volume and quality outcomes and for meaningful models that positively incentivise positive provider behaviour.

2.21 DHMS is in complete agreement that schemes should be negotiating for these, and previous submissions, including DHMS's first submission[16] to the HMI, have demonstrated work done by the Scheme and Discovery Health in this regard. Once again, our experience is that environmental constraints are the impediments to achieving this, and not a lack of effort.

Governance of funders

With regards to governance, the HMI's views are:

There are few incentives to ensure that scheme employees, trustees and principal officers always act in the best interest of consumers. Scheme incentives are too weak to ensure that administrators are held to account for delivering value for members. Schemes are not accountable to members and trustees have failed to obtain the best value for them.
The separation between schemes and administrators often seems artificial, and scheme interests are too closely aligned to administrators.

2.22 DHMS disagrees with these statements. While we cannot comment on other schemes, DHMS does not believe that the above comments from the HMI apply to it. To imply that our Trustees are not holding the administrator to account, and are not independent, is to impugn their fit and proper status, professional integrity and their dedication to ensuring the best possible outcomes for our members. We see no evidence in the Provisional Report to support these allegations and request that the HMI provide such evidence, or withdraw these statements.

2.23 To the contrary, in its 2018 reports Deloitte reaffirms the independence and arms-length nature of the relationship between DHMS and DH. In addition, the report states that the Trustees receive "regular briefings on matters relevant to the business of the Scheme" and that the contractual agreements between DHMS and DH include independence statements - thereby demonstrating that independence is actually contracted for between the entities. We comment further on the strong independence between DHMS and DH below.

[16] Discovery Health Medical Scheme Competition Commission Submission:
Private Healthcare Market Inquiry, November 2014; Discovery Health Submission: Competition Commission market inquiry into the private health sector, November 2014

Trustees and principal officers earn their stipulated remuneration regardless of the performance of the medical scheme, and that there is therefore little incentive for the trustees or principal officer to ensure that the medical scheme grows, or that healthcare and non-healthcare costs are retained as they will receive their remuneration regardless.
The Amendment Bill[17] does not adequately address deterrence of conflicted relationships, negligent conduct and fraudulent conduct of trustees and principal officers. The provisions on the penalties and removal from office in the current MS Act may not serve as a sufficient deterrence. Rather a more stringent and effective penalty system may be required. This could include, for example, that individual trustees may be held personally liable for losses resulting from negligent conduct or fraudulent activity.

2.24 We agree that the MS Act could provide for more stringent measures in this regard, and as the Scheme agrees that negligence, fraud and conflict on the part of trustees should be firmly and decisively dealt with, we have ensured that such is catered for in our Scheme Rules[18].

2.25 While the Medical Schemes Act 131 of 1998 in Section 66 deals with offences and penalties, it should be read to together with the Financial Institution Protection of Funds Act 28 of 2001 ("FIPF"), which contains provisions that hold trustees accountable with regard to conflicts of interests and misconduct:

2.25.1 In terms of the FIPF "financial institution" includes any medical scheme contemplated in section 1 of the Medical Schemes Act, 1998.

2.25.2 Section 2 of the FIPF deals with the duties of persons dealing with funds of, and with trust property controlled by, financial institutions and provides that:

2.25.3 "A financial institution or nominee company, or director, member, partner, official, employee or agent of the financial institution or nominee company, who invests, holds, keeps in safe custody, controls, administers or alienates any funds of the financial institution or any trust property—

2.25.4 (a) must, with regard to such funds, observe the utmost good faith and exercise proper care and diligence;

2.25.5 (b) must, with regard to the trust property and the terms of the instrument or agreement by which the trust or agency in question has been created, observe the utmost good faith and exercise the care and diligence required of a trustee in the exercise or discharge of his or her powers and duties; and

2.25.6 (c) may not alienate, invest, pledge, hypothecate or otherwise encumber or make use of the funds or trust property or furnish any guarantee in a manner calculated to gain directly or indirectly any

[17] Medical Schemes Amendment Bill, 2008

18 DHMS's latest CMS-approved Scheme Rules can be provided to the HMI on request, and are also available on our website.

improper advantage for any person to the prejudice of the financial institution or principal concerned."

2.25.7 The provision of the FIPF holding trustees accountable in terms of declaring interest is Section 3 and provides that

2.25.8 "A director, member, partner, official, employee or agent of a financial institution or of a nominee company who takes part in a decision to invest any of the funds of the financial institution or any trust property in a company or other undertaking in which he or she has a direct or indirect financial interest, must declare that interest in writing to the board of management or other governing body of the financial institution or nominee company, indicating the nature and extent of such interest, before such decision is made."

2.25.9 The FIPF also imposes stringent penalties and Section 10 of the FIPF provides that:

2.25.10 (1) A person who contravenes or fails to comply with any provision of Chapter 1 is guilty of an offence and on conviction liable to a fine not exceeding R10 million or to imprisonment for a period not exceeding 10 years, or to both such fine and such imprisonment.

2.25.11 (2) A court may, in addition to any penalty it may impose in terms of subsection (1), order that such person—

2.25.12 (a) pay the institution or principal concerned any profit he or she made; and

2.25.13 (b) compensate the institution or principal concerned for any damage suffered, as a result of the contravention or failure.

2.25.14 (3) A court may, in addition to any penalty imposed in terms of subsection (1) and an order made in terms of subsection (2), order that such person may not serve as a director, member, partner or manager of any financial institution for such period as the court may deem fit.

2.25.15 This practise of declaring interest is further prescribed in the rules of the Scheme and also prescribed as a provision that schemes should adopt in the rules in terms of the model rules as prescribed by the Council for Medical Schemes. In light of the latter it is relevant to indicate that the rules of a medical scheme become legally binding on the scheme, beneficiaries and any other party who has a right in terms of the contract and within the framework of the business of a medical scheme as defined.

2.25.16 In particular DHMS deals with conflicts of interest in the Scheme Rules as follows:

2.25.17 The members of the Board must avoid conflicts of interest, and must declare any interest they may have in any particular matters serving before the Board.

2.26 In addition, while the Scheme has professional indemnity policies in place, if it is established that a Trustee or officer of the Scheme acted dishonestly or fraudulently,

the Scheme shall ensure that recovery action is considered and initiated for an amount equal to the indemnification provided.

2.27 We comment further on the current remuneration structures and incentives of the Scheme, and the HMI's recommendations, below.

Administrators have far more analytical capacity and "know how" than schemes and generally make decisions on behalf of schemes, even on key issues of strategy. Even when a mandate is given by the trustees to the administrator to conduct certain activities on schemes' behalf, it is the duty of the trustees to review the outcome of such negotiations and ensure that value for money is given. The HMI further states its concern that schemes have abdicated their duties to the administrator and have no control over important aspects of their business.

2.28 DHMS denies that the Scheme's Trustees have abdicated their duties and have no control over important business aspects of the Scheme. DHMS's Trustees are highly engaged and involved in reviewing regular, detailed reports and in making all key decisions with regards to the Scheme's business and detailed evidence of this involvement can be provided to the HMI if necessary. If the HMI has evidence to support the accusation that schemes abdicate their duties and decision-making to administrators, we request that such evidence be shared with us as we do not see it in the Provisional Report.

2.29 It is true that in certain areas Discovery Health has more analytical capability than the Scheme Office. It is precisely this capability (among others) which the Scheme contracts for and Discovery Health has demonstrated to the Scheme over many years the value provided to our members by such capability. Irrespective of the capabilities of our administrator, DHMS disagrees with the statement that the Scheme Office and Trustees do not have the capability to assess, question and challenge any proposals made by Discovery Health to us. DHMS works with DH in accordance with the DHMS operational model, aligned with the Vested® outsourcing approach, which defines the Scheme Office's role as primarily one of governance and strategic oversight. The management team's diverse expertise includes medical, actuarial, risk management, business management, strategic development, financial management, investment, legal, ethics, compliance, governance and research capabilities. The Board comprises individuals with a broad array of skills and experience, including legal, actuarial, accounting, economics, governance, clinical, financial, investment and human resources. These extensive skills and experience most certainly equip DHMS to thoroughly understand, challenge and interrogate any reports and proposals made by Discovery Health.

2.30 In addition, the Board of Trustees and all board committees undergo an effectiveness review on an annual basis. Most recently, this review was conducted independently by the Institute of Directors in Southern Africa, which concluded that the Board has a high level of experience and strong leaders at Committee level[19], thus thoroughly

19 The IoDSA report can be shared with the HMI on request, under appropriate confidentiality agreements.

equipping the Board to effectively review and make informed decisions for themselves through Committee feedback to the Board.

The HMI could 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[20].

2.31 This is certainly not the case for DHMS. To the contrary, throughout the year DHMS is provided with reports[21] regarding fraud and forensics savings as well as managed care savings (and these have been made public in our annual Integrated Report[22] for the last several years). Managed care savings are also passed on to the Scheme, except in some contracts where an element of savings may be shared with providers. The Scheme is then able to factor these savings into its budgeting process for the forthcoming year's contribution pricing. In 2017 the Scheme benefitted from R5.7 billion in managed care savings and forensics savings and recoveries. The process of allocation of savings from fraud and forensics to schemes administered by DH is also transparent and such recoveries are transferred into the Scheme on a regular basis.

Open medical schemes have incurred significant losses from capitation arrangements over a period of at least 10 years. These sustained losses point to poor governance of open medical schemes. In contrast restricted medical schemes have not incurred losses on capitation arrangements.

2.32 It must be borne in mind that such capitation agreements provide security of full cover to members, security of a fixed claims experience for schemes and are based on risk sharing on managed care and disease management (rather than fee-for-service). The fact that schemes incur losses on capitation arrangements does not imply that no value is added by the capitation provider: the key point is that the Scheme's claims experience would be worse if there was no capitation, i.e. the Scheme would be worse off retaining the risk on a fee-for-service basis as the capitated provider is able to better manage the utilisation risk. The change in quality delivered by a contract needs to be considered together with the financial outcome and the right balance needs to be achieved. It is often desirable to pay a little more if much better quality of care can be achieved.

2.33 These arrangements allow the Scheme to contract the services for less while still allowing the service provider to operate at a reasonable margin – making for a sustainable contract. If the capitation contract always ran at a loss to the provider it would be unsustainable to the provider. The decisions made by a board of trustees to establish or continue with such arrangements is therefore a complex one, considering a range of member needs and negotiating for best outcomes, and does

20 HMI Provisional Report, page 457.
21 Such reports can be shared with the HMI on request, under appropriate confidentiality agreements.
22 The he DHMS 2017 Integrated Report is available at https://www.discovery.co.za/medical-aid/annual-reports-and-financials.

not reflect poor governance based simply on apparent losses. DHMS continually reviews its capitation agreements and will terminate or revise those agreements that are not in the best interests of the scheme and its members.

2.34 DHMS cannot comment on the capitation agreements entered into by restricted schemes, nor on the quality of their governance, but we note that the population variation in restricted schemes is usually much lower than in open schemes and that this may enable such schemes to make better assumptions regarding capitated benefits.

3. Competition in the private healthcare market

3.1 DHMS notes various commentary throughout the HMI's preliminary report alleging, *inter alia*, that:

- DHMS is a dominant open medical scheme;
- DHMS's position in this industry has grown, in part, through a series of amalgamations with smaller schemes;
- The funders market is extremely concentrated;
- Competition in the funders market is not as vigorous or competitive as it should be;
- There is a lack of innovative entry and limited expansion by funders on the competitive fringe; and
- Consistently high market shares in the funder space indicates a lack of effective competition.

3.2 While DHMS does not concede the market definitions nor market share estimates utilised by the HMI in its preliminary report (and reserves its rights to make more detailed submissions on this point and those listed above at a later stage), we make the following high-level submissions:

3.2.1 Even if DHMS is found to be dominant in a particular market (howsoever defined), it is trite that it is not anti-competitive for a player to be dominant or have a high market share, it is only anti-competitive for that player to abuse its dominance.

3.2.2 Indeed, the Competition Tribunal recognised in BATSA, the seminal case in this regard, that, "in the absence of a coherent theory of harm and evidence of foreclosure, the inference to be drawn is that [JTI's] disappointing performance derives from the superior product offering of [BATSA] or its superior competitive strategy". In reaching this decision, the Tribunal placed great store on the promotional opportunities available to the BATSA's rivals; the complainant's own resources, including international brands and experience; and alternative mechanisms and sites of marketing and promotion "studiously ignored" by the complainant.

3.2.3 In this regard, DHMS's position in the industry can be likened to that of BATSA. DHMS has achieved its position within the market (howsoever defined) through innovation and its dynamic approach to competition – indeed its market share is attributable to the long-term benefits of investing in systems, innovation and expertise over time. In this regard, DHMS has taken advantage of competitive opportunities within the industry to expand its offering and differentiate itself from its competitors, strategies which have successfully grown its market share. We note in addition that although we have a high market share, there is high churn of members entering and leaving the scheme annually – about 360 000 entering and 320 000 leaving. This demonstrates the competitive nature of the market as members can and do switch between schemes easily. Even if the scheme is large, it therefore has to remain competitive in order to attract and retain members. DHMS accepts that it is a large player in the industry, but it has never abused its sizeable position in this regard.

3.2.4 In any event, DHMS (and other funders) are not-for-profit schemes and, as such, the usual incentives which might point to market power within an industry do not apply to funders.

3.2.5 Furthermore, to the extent that there is a lack of innovation in the industry (which DHMS does not comment on at this stage), this cannot be placed at DHMS's door. Indeed, it is difficult to understand how the HMI criticises DHMS for its innovative approach and success in the industry on the one hand, while simultaneously alleging that there should be more competition within the funder space. DHMS clearly faces a competitive constraint from other open medical schemes (and restricted schemes on a limited basis) otherwise its approach to pricing and benefit design, and its efforts to innovate and attract new members would be unnecessary.

3.2.6 DHMS is of the view that it is the existing regulatory framework (and not a lack of competition) that hinders the entry of new medical schemes, and the expansion of some others. In this regard, the process of registering a new scheme is convoluted and an injection of capital is required. Addressing these constraints would likely open the door to new entrants. Furthermore, DHMS is required to be continuously innovative due to competitive pressures but, as expanded on elsewhere in this submission, it is hindered in these efforts by regulatory constraints, particularly relating to the PMBs and coverage at cost, as well as the HPCSA impediments to contracting innovatively with providers. Other funders will be similarly limited.

3.2.7 Finally, DHMS has achieved its higher market share within the open medical scheme space through organic growth, driven by its innovation and competitive dynamic – and not as a result of amalgamations with smaller schemes in the industry. In the Scheme's opinion this organic growth reflects the value of our offering to consumers in terms of benefits, cost and service levels. The Scheme's average net rate of growth of beneficiaries from 2000-2017 was 9.7% including and 9.6% excluding amalgamations per annum, and from 2009-2017 it was 4.0% including and 3.9% excluding amalgamations per annum. It is therefore clear that only a fairly small portion of the annual growth of the Scheme has been due to amalgamations. In Appendix A we provide a table of this growth comparison per annum.

4. The DHMS-DH relationship and non-healthcare expenses (NHE)

The HMI concludes that the Scheme's administrator, Discovery Health, earns unusually high returns. In addition it states that DH's service fees are higher than necessary given economies of scale; that DHMS is "locked-in" (with regards to its contract for administration and managed care service provision with DH, and fees paid) and that open schemes are "captured".[23] Although it acknowledges that it is possible for DHMS to terminate its contract with DH it states that "in reality there is no threat of DHMS switching to another administrator" and that if a medical scheme is unlikely to go to tender the administrator is under less pressure to pass on any benefits of economies of scale through lower administration fees.

The HMI is also of the view that the separation between schemes and administrators often seems artificial, and that the administrator effectively controls and manages the medical scheme due to information asymmetry between medical schemes' trustees and administrators, often leading to real control of the scheme resting in the hands of the administrator.

4.1 DHMS has an extensive focus on fees paid to the administrator which is primarily exercised through our Non-healthcare Expenses Committee. The Committee ensures that the Scheme receives value for money for amounts paid to the administrator, that it benefits from economies of scale, that the fees are appropriate when measured against the relevant peer group and that the administrator is motivated to invest in innovation to the benefit of the Scheme and its members. The economies of scale are passed on through annual fee increases which are at or below CPI whereas the administrator's base costs increase at higher than CPI. In addition, the scheme contracts with DH to invest a substantial amount each year in innovative assets and services which benefit the scheme and its members, and in this way, derives further benefits from economies of scale.

23 HMI Provisional Report, pages 10 and 162

4.2 DHMS notes the HMI's comments regarding the profitability of DH. The Scheme's focus and interest is not on DH's profitability but rather on the value provided to the Scheme by DH. In this regard the obligations of the Trustees are to ensure that they consider the fees paid to DH and the terms of the administration and managed care contracts are fair, competitively priced and beneficial to our members - which they do, as detailed in this section.

4.3 The HMI appears to have misunderstood or glossed over the nature of the Vested®[24] contractual relationship the Scheme has with DH. The Vested model requires extremely robust contracting specifics including clearly defined outcomes and service level agreements.

4.4 In terms of the quantum of fees paid to DH, and the HMI's views that these are higher than necessary, the fees paid must be considered relative to value provided as well as the scope and quality of services required. The Scheme monitors the quality of service via a range of metrics that measure member, broker and doctor sentiment on an ongoing basis. Delivery of service is also closely monitored by the Scheme. In the event of a target being missed, DH discusses the causes and the measures it is implementing to prevent future occurrences. These metrics are reported to the Scheme Office every month and exceptions are reported to the NHE Committee.

4.5 With regards to considering value provided and previously submitted to the HMI[25], in 2013 and 2014 Deloitte developed a methodology to quantify the value received by DHMS from DH. This methodology was updated in 2015 and Deloitte reviews this on an annual basis. The methodology uses comparative industry data and assesses the value received in terms of various components like providing administration services, managing the cost of claims, making members healthier, attracting and retaining members and innovative offerings. For the last four years of 2014, 2015, 2016 and 2017 the value obtained for the Scheme from DH has respectively been R1.73, R1.85, R2.00 and R2.10 for every R1.00 spent by DHMS. In its 2018 reports, Deloitte concludes that it is evident that DHMS receives more value than the actual fees paid to DH.

4.6 In terms of independence and ensuring that the Scheme is controlled and managed by the Scheme and not the administrator, the Scheme's governance structures include ten board committees (Audit; Risk; Clinical Governance; Product; Investment; Non-healthcare Expenses; Stakeholder Relations and Ethics; Remuneration; Disputes; and Nomination). These Committees are, according to their respective mandates, made up of Trustees and independent members as required for additional skills and

[24] The contractual relationship between DHMS and DH makes use of a trademarked and very specific model called Vested (rather than a loose "vested" arrangement): Vested® is an outsourcing model, methodology, mindset and movement for creating highly collaborative business relationships that enable true win-win relationships in which both parties are equally committed to each other's success. When applied, a Vested® approach fosters an environment that sparks innovation, resulting in improved service, reduced costs and value that didn't exist before – for both parties. Vested® is based on award-winning research conducted by the University of Tennessee's College of Business Administration. (Source: http://www.vestedway.com/).

[25] Annexures to the Discovery Health Medical Scheme Private Healthcare Market Inquiry Data Request, 31 May 2015

for increased independence. The Committees engage robustly with Discovery Health in areas of their mandates where DH's input is required, and provide detailed reports to the Board regarding their activities and decisions taken. Some of the Committees have very limited or no interaction with DH, and so operate completely independently (Nomination and Remuneration) and the Disputes Committee as governed by the Scheme Rules, consists of panellists independent from both DH and DHMS. Information regarding the Scheme's governance has been previously submitted to the HMI, but the Scheme is willing to engage further with the HMI in this regard if required.

4.7 The Scheme has commented on information asymmetry and the Scheme's capabilities in section 2 above. In addition the Scheme Office is kept well informed through, among other mechanisms, participation in the design of products and services in various forums where proposals relating to these are discussed and critiqued. This includes representation by the Scheme Executives at combined DHMS-DH forums where initial approvals are obtained. Subsequently, proposals are presented to the relevant board committees of the Scheme for review and recommendation to the Board for approval. Once approved, periodic reports are provided to the relevant Committees for ongoing monitoring and to inform the Committee regarding progress.

4.8 As has been previously submitted to the HMI[26], in 2013 DHMS commissioned Deloitte to conduct a review of the transactional and relational governance in the relationship between DHMS and DH. The resultant report was provided to the HMI and affirmed that the Scheme has a robust and balanced governance framework in place that is evolving with the Scheme's needs and facilitates the achievement of independence and an arm's length relationship with DH. In 2018, the Scheme requested Deloitte to update the report. The key findings in the updated report are:

- The reporting structure from the Administrator and Managed Care provider has been formalised. The Reporting Framework Agreement, together with the RASCI matrix facilitate collaboration between the Scheme Office and DH in implementing strategy and allows the Scheme Office to ultimately have oversight over all activities and functions.
- Service levels and performance metrics are monitored via Service Level Reports with external verification of service levels provided for in the Agreements. The Agreements allow the Scheme Office to assess, question and challenge any proposal or comments made by the Administrator.
- The 2018 administration and managed care agreements between DHMS and DH embody the Vested® outsourcing business model, a best practice outsourcing model. This business model empowers both parties to deliver on the agreements independently, while working towards and being measured against a common shared vision. This is formalised via a comprehensive contract governance

[26] Annexures to the Discovery Health Medical Scheme Private Healthcare Market Inquiry Data Request, 31 May 2015

structure, and supported by the establishment and implementation of Relationship Management and Innovation Committees as outlined in the Agreements.

- The services provided by DH to DHMS under the 2018 Administration and Managed Care Agreements are captured in legally binding annexures to the Agreements. The services have been comprehensively scoped and are categorised by function. Service level metrics and quantifiable minimum service levels have been defined. The service functions and service classes to which service level metrics and minimum service levels are linked can be broadly traced back to individual services, groups of services or categories of services. Measurable service levels also includes monitoring of broker and member perceptions.
- Fees are linked to performance measures via penalties for below target performance[27]. The Agreements allow for collaboration to arrive at revised fees on policy anniversary, failing which a CPI increase will apply.
- The Agreements provide for a commencement date and a fixed duration, with the option to extend for an additional period equal to the original term, as well as renewal periods after the first renewal period.
- The Agreements provide for an additional Agreement to be entered into prior to termination, which would include a transfer management process to effect seamless handover should the services from the administrator be terminated. Continuity of service is also provided for by requiring that information is handed over in a medium capable of manipulation that would enable another administrator to use it for the purposes of administering a medical scheme.
- The Agreements provide for indemnity by the Administrator/Organisation and indemnity by the Scheme under specified events, as well as a liability threshold above which DH shall be liable if the specified events arise. They also clarify that the DHMS and DH are independent contracting parties. The indemnities together with the independence statements assist in interpreting the relationship as arms-length.
- The Board Meeting minutes provide evidence of regular briefings on matters relevant to the business of the Scheme. Industry updates are provided at a Committee level.
- The Scheme Office's capacity has increased over the last couple of years and positions that are occupied cover a wider variety of responsibilities than in previous years.
- The Board conducts annual self-assessments of the Chairperson, Trustees and overall Board performance. The 2017 DHMS Integrated Report states that the outcome from the Trustee peer and self-rating evaluation did not identify any material weaknesses. An evaluation and assessment of the Board was conducted

[27] The Scheme notes that there are regulatory limitations to positive incentives for performance and this is counter to the principles of Vested® contracting as well as what is commonly held to be best business practice (reward for good performance). This is another example of a regulatory barrier to innovation.

by the Institute of Directors in Southern Africa NPC ("IoDSA") in January 2018. This was an independently facilitated self-appraisal process with the views of the individual Trustees on the performance of the Board as a whole and individual Board members' effectiveness. It concluded that the Board has a high level of experience and strong leaders at Committee level.

Deloitte concludes:

"In 2013, Deloitte performed a Governance Review of the DHMS and developed a Roadmap with recommended actions or activities, as well as urgency levels. We have reviewed the recommendations against the documents provided by the DHMS and commented on the progress that DHMS had made against the 2013 Roadmap.
This (2018) report highlights the updates and progress that DHMS made against the Roadmap developed in the 2013 Governance Review to ensure proper governance and governance structures.
A new operating model was designed that should allow DHMS to interface more efficiently and effectively with its stakeholders by enhancing internal processes and promote working as a cohesive and integrated team.
In addition, the capacity in the Scheme Office has increased with a broader skillset being represented by the various positions in the Scheme Office.
Various developments such as the adoption of the Vested Outsourcing model, fixed duration Agreements, transfer management process, measurable service levels and indemnity clauses supports the independence and differentiation between DHMS and DH."

This independent review and assurance provided to the Trustees are sufficient to reassure them that independence is in place, and should also reassure the HMI in this regard.

4.9 While the relationship between the Scheme and DH has been a long-standing and highly successful one, should DH's standard of service to and care of Scheme members, its ability to innovate and to evolve the healthcare system towards a more beneficial form for our members, and generally its value provided to the Scheme drop below acceptable levels the Trustees would reconsider the long term nature of its relationship with DH. To imply that the Trustees would not do so is incorrect and without foundation, and this should satisfy the HMI's concerns regarding a constraint on competition.

4.10 In their 2018 Governance Review, Deloitte comment that: "The DHMS and DH Agreements are set up in line with the Council's guidelines on Administration Agreements, dated July 2012. The independence and differentiation between DH and DHMS are maintained by:

- The adoption of the Vested® Outsourcing business model;
- The fixed duration of the Agreements instead of the indemnity nature;

- A transfer management process and the requirement of information handover should an agreement be terminated;
- Measurable service levels with penalties for under performance. These service levels can be reviewed by third parties.
- The indemnity clauses in the Agreements supporting that DH and DHMS are independent parties;

These aspects confirm that DHMS is in a position to, at any time, terminate the Agreements and seek the services of another service provider."

The HMI finds no clear separation of commercial interests between schemes and their administrators and views closely aligned medical schemes as "quasi profit maximising schemes" with their growth driven by their for-profit administrators.

4.11 DHMS disagrees with this view. DHMS pays DH an agreed fee, the value of which has been extensively interrogated and with which the Trustees are satisfied, as we have explained to the HMI in the past as well as in this submission. Beyond that fee, there is no way for DH to access any DHMS funds: the reserves and surplus held by the Scheme are for the benefit of DHMS members only. DH's only revenue source from the Scheme are the disclosed fees paid to it.

4.12 DHMS notes that growth is most certainly one of the factors contracted for by the Scheme with DH, and should DH fail in this regard it would be of significant concern to the Trustees. In an environment of high inflation, increasing utilisation and demographic effects, the Scheme is under continual pressure to maintain affordability and comply with legislated requirements such as solvency. The Scheme and the administrator's interests are aligned in this regard although for different reasons – the Scheme requires growth to remain competitive, stable and sustainable, and the administrator for its profit motives. This is a healthy relationship, with strongly aligned incentives, which ultimately benefits the members of the scheme.

The HMI finds that DHMS pays more total administration fees than next three largest open schemes but lower fees when viewed as percentage of gross contribution income, and that there is no evidence of economies of scale in the administrator market. The HMI also comments that non-healthcare costs for the ten largest schemes in South Africa range from 5% to 13.4% of gross contribution income compared to only 3% of GCI on average for OECD countries, and that it seems that trustees are generally satisfied with CPI-linked increases in member contributions year after year.

4.13 In an earlier submission[28], DHMS included the Deloitte Operating Model and Governance Review commissioned by the Scheme in 2013, as discussed above. That report contains a detailed section on economies of scale in the third-party administrator market, and compares South Africa with the United States and

[28] Annexures to the Discovery Health Medical Scheme Private Healthcare Market Inquiry Data Request, 31 May 2015

Australia in this regard. The report concludes that for large third-party administrators, economies of scale only occur for a limited range of activities and that in fact DH has over time passed on a reasonable proportion of the benefit that arises from scale to the Scheme.

4.14 As part of the work done in 2018, Deloitte also benchmarked DHMS against its peers in the South African market (which work was also previously done in 2013). Key performance areas used for the exercise were financial strength, growth and sustainability; non-healthcare expenses; compliance, governance and reputation; and innovation and quality. Deloitte finds that DHMS and one of the benchmarked schemes tied as the fourth-best and fifth-best performing schemes amongst their peers (of a total of 13 schemes) for non-healthcare expenses, and comments: "DHMS's NHE (as a % of CGI) was 10.2% in 2016. This decreased steadily from over 14% in 2012. From the Value Add Assessment it can however be seen that the value created by the DHMS administrator, DH, far exceeds the cost that is paid to them."

4.15 DHMS makes use of an integrated outsourced model, which as previously submitted to the HMI[29], provides better value to the Scheme and its members than a fragmented model.[30] However, as we detail in the section titled "Publishing comparative data" below, it is very difficult to compare the costs and relative performance of administrators.

4.16 In this regard, we note that restricted schemes' expenditure would always tend to be lower than that of open schemes due to the different types of services required by these schemes and to the majority of these schemes having mandatory membership, and that care must therefore be taken when comparing open and restricted scheme costs. We also note that a comparison with OECD countries is equally problematic due to the differences in these systems versus South Africa's voluntary private healthcare system and we refer the HMI to a paper by the World Health Organisation on this topic, which also points out the need to assess the value received for these costs instead of simply the quantum[31].

4.17 The Scheme notes that the MSAAB proposes an amendment regarding the Regulator's powers to restrict a medical scheme's total non-healthcare expenses (an extension from the relevant provision in the current MS Act). Such an amendment effectively grants the Registrar the power to control a large number of wide-reaching and intrusive financial decisions made by schemes. This is contrary to the principles of good regulation. Financial decision making is a commercial decision and delegated by the board of trustees to the relevant officers of a scheme, and overseen by the

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[29] Annexures to the Discovery Health Medical Scheme Private Healthcare Market Inquiry Data Request, 31 May 2015.

[30] In their 2013 reports, Deloitte stated "Based on the analysis of the type of model, it appears that the model in which administration and managed care have been outsourced to the same provider (integrated), incurs on average 15% lower NHE than the model which outsources administration and managed care to different providers (fragmented model). It can be seen that an integrated model (i.e. average rank 3.89) out performs a fragmented model (i.e. average rank 6).

[31] Administrative costs of health insurance schemes: exploring their reasons for variability, Discussion Paper Number 8, 2010 by the World Health Organisation. Source: http://www.who.int/health_financing/documents/cov-dp_e_10_08-admin_cost_hi/en/.

board of trustees which has a legal duty to ensure the prudent spending by medical schemes. The trustees' duties are already sufficiently governed by the MS Act without such overreach: If the trustees were to act in breach of their duties, then they may be held jointly and severally responsible for the consequences of their breach. It should therefore not be necessary for the Registrar to usurp the powers of trustees and make or constrain non-healthcare related decisions for them. The unintended consequence of such a provision is that the Registrar is empowered to make decisions or restrict decision making despite the trustees being appointed with the express purpose of safeguarding the members' interests. The Registrar is not in a position to determine how a scheme should make financial and commercial decisions and should not be permitted to effectively co-manage the scheme unless it assumes co-responsibility for the performance of the scheme, which it does not. This amendment also allows for the unequal treatment of different schemes, and so is counter to sound market operation as well as fairness. We attach some supporting material as Appendix D for the information and consideration of the HMI.

The HMI also states that Discovery Health has market power in respect of DHMS, as demonstrated by the fact that Discovery Health can afford to take several years to reduce its fees to more competitive levels.

4.18 As commented above, the Scheme's focus and interest is on value provided and continued innovation for fees paid to DH. DH's ongoing appointment is dependent on this value provided and the pattern of fees paid by the Scheme are reflective of the satisfaction of the Scheme as demonstrated by the value added and extensive innovation delivered, rather than market power. As noted above, the fees paid to DH have decreased in absolute and real terms over the past several years. As also noted above, DHMS receives approximately R2.10 in value for every R1 paid in fees to DH, and the Trustees regard this as an excellent value exchange and are thus satisfied with the level of fees paid to DH. The Vested outsourcing model is predicated on the development of a long term, mutually beneficial contractual relationship in which the supplier has strong incentives to continue investing in innovation and services which benefit the buyer. This is very different to a transactional relationship which would measure success purely on the buyer achieving the lowest possible price from the supplier. The Trustees remain convinced that the current contractual model provides excellent value for the scheme and its members.

The HMI states that the vested outsourcing model the Scheme has with DH requires it to manage only one open scheme at a time. This poses serious competition concerns as neither size nor the nature of the relationship with an administrator should determine who a scheme contracts with.

4.19 This statement is factually incorrect. Neither the Vested outsourcing model nor any other contract or agreement between DH and DHMS requires DH to only manage one open scheme at a time. This is a strategic choice that DH has made on its own behalf.

We note, however, that should an administrator administer more than one open scheme material conflicts of interest could arise in, among other areas:

- Negotiations with providers;
- Differentiation of services provided;
- Should one open scheme wish to follow a strategy to the detriment of the other open scheme;
- Assisting each scheme in a situation where both schemes may wish to tender for the same employer group;
- Marketing support; and
- Underwriting strategies.

4.20 We conclude that if an administrator were to administer and market two or more open schemes this may actually dampen competition, as well as create conflicts of interest between the administrator and its clients with potential for misaligned incentives. Such a scenario may even have the potential to create a platform for collusive conduct.

4.21 Finally, it is submitted that the size and sophistication of an administrator necessarily does factor into who a scheme contracts with as adequate and appropriate capacity is required.

5. Communication with members

The HMI states that ineffective communication between medical schemes and their members affects the ability of members to hold trustees accountable for the manner in which they run the medical scheme.

5.1 DHMS acknowledges that communicating with members is a challenge. There are many reasons for this, including a reluctance on the part of the majority of members to engage with the Scheme outside of their immediate personal healthcare funding concerns (which is not to detract from a minority of members who do actively engage). Information and communication overload plays a part and in many instances it is likely that our communications may often go unread.

5.2 This is not to say that the Scheme does not want to change this. We also work towards engaging members in taking ownership for their own health, wellness and healthcare, as we believe that educated and responsible members are better able to partner with their healthcare providers to optimise outcomes.

5.3 Due to this challenge we target the timing and content of our communications to member needs and interests as best we can, across various media (written, electronic, SMS, video campaigns and newer innovative channels like the App and Ask Discovery, the artificial intelligence-based question answering facility on the website). Following each product launch and the contribution increase announcement members are afforded an opportunity to review their plan choice. This happens on an annual basis and the communication content includes a guide to their chosen plan together with information on where additional information can be found on other plan types. The communication provides members with a breakdown of what their contributions are

for the year ahead, and the product information brochure is attached to the communication. Members are also provided with information on how they can make a change which includes self-service channels by logging onto the website or using the Discovery App and understanding how they can change their health plan and then choosing a plan that suits their needs by 31 December each year or by speaking to their financial adviser.

5.4 At any time of the year members will also be sent information relevant to their specific health needs, for example guides on pregnancy and giving birth to expectant mothers, and detailed procedure guides and other information for members authorising hospital admissions.

5.5 In May each year, members receive notification of the AGM which includes the DHMS performance highlights and a link to access our full annual Integrated Report. In an election year information about the nomination process to be elected as a Trustee and the subsequent Trustee elections is provided, which includes information on all of the candidates and detailed information about the requirements for voting for their chosen candidate, whether or not they are able to attend the AGM in person.

5.6 An example of lack of interest and engagement by members is the Scheme's annual Integrated Report. DHMS invests considerable time and effort to compile a detailed, user-friendly and stakeholder-oriented document which is published each year, communicated to all members and available on the internet site in reader-friendly sections, with printed copies having been made available at physical member touch-points as well as at the AGM in the past. In this document we explain the nature of the Scheme, how it operates and how the Trustees ensure that members receive value for money, as well as key performance indicators for the Scheme and information about managed care programmes and benefits provided to members. The document also contains detailed contact information, information on how to escalate a complaint and an e-mail address specifically for related comments and questions. For the Scheme's 2016 Integrated Report (published in 2017), we estimate that there were approximately 283 views of the document in total (including printed and online), which from a beneficiary base of around 2.5 million at that time is very disappointing.

5.7 DHMS agrees that practically speaking, as the HMI acknowledges, it is more efficient to outsource the volume of incoming communication (including complaints) received by the Scheme to an administrator. However, our escalations process is highly efficient, is governed in accordance with Scheme requirements and results in complaints and complex cases being addressed personally at the most senior level, both in DH's structures and by the Scheme Office, with due reporting to the Board. The operational framework and performance trends are reviewed annually by the Scheme and improved in line with best practice. Where necessary our Trustees engage directly with members and have invited members to attend Board meetings in the past. As a standard we include a "member engagement" item on the AGM agenda, where members interact directly with Trustees.

6. Pharmaceutical and consumable costs

6.1 DHMS notes the HMI's comments regarding the possible cross-subsidisation of pharmaceuticals pricing in the public and private sectors and its view that strengthened competition between the two sectors would influence pricing and product outcomes across both sectors, and the Scheme also notes the absence of recommendations regarding competition and pricing in the pharmaceutical industry ("pharma").

6.2 DHMS is aware of the investigation launched in June 2017 by the Competition Commission into the exorbitant pricing of certain cancer medications by three large multinational pharmaceutical manufactures. These were Roche, Aspen, and Pfizer, who were also alleged to engage in anticompetitive behaviour including evergreening of patents, and other exclusionary practices. As soon as this investigation is completed, DHMS would welcome the incorporation of the results of this and any other related investigations into the pricing of pharmaceuticals, medical devices and consumables into the HMI's Final or even a later supplementary Report as the cost of these in general, and specifically high cost medicines are a significant concern for the Scheme and private healthcare consumers. Medicines overall are the third highest cost driver for DHMS after private hospitals and specialists, and the increasing quantity of high cost, newer, novel drugs like biologics, in the context of the increasing burden of disease where such medicines are indicated, is a source of growing concern. Adding to this is the lack of adjudication of single exit prices and whether these remain appropriate, given the growing utilisation that is not integrated into maximum allowable price increase reviews that are determined each year.

6.3 In addition, when medicines are included in the State Essential Drugs List they are then considered to be PMB level of care in the private sector context – although these may be procured by the State at significantly discounted State tender prices, thus increasing the private sector's price/cost exposure significantly. Due process on determining affordability, appropriate access, fairness and non-discrimination is not followed when a PMB status is declared. There should be clear legal or regulatory guidance and precedent for PMB status to be conferred. Such recommendations could include the easing of the requirements and processes for parallel importation[32] or the establishment of a central procurement mechanism in collaboration with the National Department of Health ("NDoH") which would allow both the public and private sectors to benefit. Another recommendation could be towards improved efficiency and capacity (possibly supported by the private sector) of the South African Health Products Regulatory Authority (SAHPRA) to register cheaper biosimilars as soon as possible, and to encourage the Trade-Related Aspects of Intellectual Property Rights provisions for compulsory licensing to enable early entry of generics before originator patents expire, where appropriate. Price benefits to consumers are not a

[32] A footnote on page 226 of the Report states that "Section 15C of Medicines and Related Substances Control Act, (Act 101 1965), as amended, allows for parallel importation following a granting of a permit by the Minister of Health. However, the stringent requirements and difficult processes that must be followed have prevented parallel importation from occurring in any substantial manner".

consideration in SAHPRA's mandate when registering new medicines, and these should be taken into consideration by both SAHPRA and the NDoH's Pricing Committee.

6.4 DHMS is concerned that the Pricing Committee will not consider country confidential medicine pricing specifically for South Africa (sector-wide) from pharma to allow affordable access within the country without the threat of international price benchmarking, which appears to be in conflict with the transparent pricing legislation and system.

6.5 DHMS recommends some simple interventions to alleviate these pressures e.g. appropriate pricing of existing treatments with a key focus on affordable generic prices and considerations of claims volume growth in adjusting prices, aligned with sustainable access. Even if biosimilars and first to market generics reach the market promptly, it does not assist consumers if they are unaffordable.

6.6 Commercial arrangements between pharma and healthcare providers in the private sector may negatively impact affordable medicine prices for consumers. The regulator should strive to efficiently police these activities that are against the spirit of the legislation and preclude the broadest and most affordable access to life-sustaining medication. In this regard, section 18C of the Medicines and Related Substances Control Act No 101 of 1965, as amended, compels the Minister to make regulations relating to the marketing of medicines and a related, enforceable code of practice. The Marketing Code Authority[33] already has such a code of practice which has been drafted with the full participation of the pharmaceutical industry, and which could be granted legislative effect. This code specifies what practices are and are not allowed in terms of promotion of medicines.

7. Elections and appointments

The HMI states that stakeholders are concerned that the process of electing trustees in some instances is not always fair and transparent as there are features of administrator capture, manipulation and undue influence, and that good scheme governance requires the implementation of transparency measures in the schemes' processes to ensure that trustee appointments are transparent and without favour.

7.1 DHMS agrees that elections processes must be fair and transparent. DHMS does not agree that there are "features of administrator capture, manipulation and undue influence" in its trustee elections, and the HMI has provided no evidence to substantiate this comment. Please see Appendix C for a description of the measures that the Scheme has implemented in this regard.

[33] http://www.marketingcode.co.za/

8. Prescribed Minimum Benefits: the HMI's analysis and results

The HMI states that schemes are not sufficiently effective in using buying power to negotiate contracts that would decisively benefit consumers by improving quality of care and achieve savings in premiums and reduced out of pocket expenditure, for example in instances of payment from savings accounts instead of risk pools; and the HMI further states that while in-hospital PMB diagnosis claims were largely covered, there was less compliance for out-of-hospital conditions.

8.1 DHMS notes that in working to improve quality of care for the benefit of consumers, we have successfully implemented various governance projects in a collaborative approach with various professional societies. In the course of this work we promote the establishment of clinical registries for the collection and reporting of clinical metrics and outcomes, and we progressively develop outcomes-based reimbursement models.

[redacted]

8.3 In its annexure on PMBs the HMI has published tables identifying PMBs paid from savings and "unpaid" claims. The Scheme has discerned that the HMI's method of identifying PMBs is incorrect. The PMB flags that were specified by HMI in their data request (based on ICD10 codes) do not consider whether the claim was actually a PMB after the clinical assessment of the patient. We have also demonstrated that close to 50% of the claims identified as "unpaid" did not result in any member liability as these included contractual savings (where contracts do not allow balance billing). There is also no verification that any balance is actually collected from the member by the provider. We request that the HMI correct these incorrect results or remove this analysis from the Final Report.

8.4 Further, some administrators did not comply with the data specification and include PMB flags, adding greater uncertainty to how results were obtained. The statements regarding lower compliance on out of hospital PMBs with payment from savings is incorrect, as is the HMI's finding that the PMBs are not a primary driver of cost escalation. These concerns have been clearly identified to the HMI and we have requested the withdrawal of the statements in this regard; however this objection has not been noted in the Report and nor has any action been taken. We again request the retraction of these damaging statements and analysis results, on the basis that they are clearly incorrect and misleading.

9. Broker fees and medical scheme growth

The HMI notes that CMS reported broker fees for open medical schemes (inclusive of marketing, advertising and distribution fees), indicate that Fedhealth spent the most at R113.70 per average member per month (pampm) in 2016 (for growth in beneficiaries of 2.4% from 2015) followed by Momentum Health at R103.70 pampm (for growth of 7.3% from 2015) and Bonitas at R103.30 pampm (for growth of 15.1% from 2015). The CMS' report also shows that DHMS spent significantly less at R90.60 pampm (for a growth of 1.6% from 2015). The HMI comments that because of DHMS's size, its marketing fees are spread over significantly more members and it would expect there to be economies of scale for large medical schemes as the marketing fees could be spread over significantly more members.

9.1 We have responded regarding economies of scale in section 4 above.

9.2 We also note that the HMI appears to have considered the value of broker commission only in the light of scheme growth. We believe that broker fees should not be considered relative only to new members. Firstly the change in membership mentioned by the HMI reflects a net position (ie new members less exiting members), and secondly, in the Scheme's opinion, brokers' value is significant in terms of their ongoing relationships with and support given to members with respect to queries and annual benefit selection throughout the duration of membership.

The HMI found that the brokers had significant exposure to DHMS. Submissions from brokerages revealed that their revenue from DHMS ranged from about 50% to over 70% of their total revenue. Brokers' exposure to Discovery as a group is even more significant if other Discovery products are included. The inquiry noted that the large percentage of revenue from one medical scheme reflects the large market share of that scheme. However, it is likely that where a broker receives a large portion of income from one medical scheme, that broker would want to maintain good relationships with that medical scheme.

9.3 Payments to brokers are made in line with regulated payment caps and should brokers recommend other schemes to their clients rather than DHMS they would receive equivalent funds in that regard. DHMS's broker contracts are fully aligned with regulatory requirements and follow such guidance as provided by the CMS from time to time, for example in its Circular 17 of 2018 ("Final guidelines for preparation of broker agreements in compliance with Section 65 of the Medical Schemes Act, No. 131 of 1998 (the Act) and Regulation 28 published in terms of the Act"). All brokers must be Financial Advisory and Intermediary Services Act ("FAIS") accredited, and also accredited by the CMS (which in turn requires FAIS accreditation).

Administrators and other companies in the group pay additional funds (either as fees or in the form of intercompany transfers) to loyalty and wellness programmes. The lack of transparency surrounding the funding of these programmes may allow medical schemes and their administrators to circumvent regulations through increasing the commission brokers receive. This may provide them with an unfair competitive advantage in the market.

9.4 As described above, all payments made to brokers by the Scheme are made in accordance with relevant regulations.

9.5 With regard to wellness (in the sense of working towards proactive rather than reactive health outcomes) however, we note that the HMI has focussed on the potential competitive advantage to schemes and administrators of wellness programmes and screening benefits, and at related broker commission payments.

9.6 As detailed elsewhere in this submission, DHMS strongly believes in encouraging member engagement with their own health, and in the value of the science-based Vitality programme in improving the health of members (and so reducing claims costs and contributing to Scheme sustainability as well as reducing moral hazard) as previously submitted to the HMI[34].

9.7 DHMS's existence is based on our social contract with our members, and beyond the value to the membership as a whole of reducing claims costs the Scheme is invested in its role as a responsible citizen in society: supporting, assisting and prompting our members to be healthier is part of our core values and purpose[35].

9.8 As the HMI acknowledges, the funding of wellness-related initiatives, devices and so on is not permitted by the MS Act, as it is not considered to be part of the business of a medical scheme: "The separation between the medical scheme and wellness/ loyalty products are necessary as the MSA precludes medical schemes from incurring any expenditure that is not healthcare related. Section 26(5) provides that no payment in whatever form shall be made by a medical scheme directly or indirectly to any person as a dividend, rebate or bonus of any kind whatsoever."[36]

9.9 DHMS funds a range of medical devices, which include medical screening, prevention and diagnostic devices. Such devices include, for example, blood pressure monitors, scales, nebulizers, wheelchairs, walking sticks etc. The Scheme also for a time funded certain wearable wellness devices to assist doctors and patients monitor and diagnose disease in the pursuit for quality-driven healthcare and to encourage the development of personal health and wellbeing as a personal goal, thus aligning members' own goals with the Scheme's financial wellbeing (as they result in lower healthcare costs and can play a pivotal role in preventative care). Funding these devices was in accordance with our CMS-approved 2015 Scheme Rules; however we were instructed by the CMS to cease funding these during the course of 2015.

9.10 This matter has since been resolved to the CMS' satisfaction, and while the Scheme understands the constraints the CMS faces under the current definitions in the MS Act we hold to our belief that evidence based and reliable wearable health and wellness devices and technology are inherently healthcare devices.

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[34] Discovery Health Medical Scheme Competition Commission Submission: Private Healthcare Market Inquiry, November 2014; a presentation by Emile Stipp on "Impact of Vitality engagement on Discovery Health Medical Scheme", 2016; DHMS and DH presentations to the HMI, March 2016.

[35] DHMS's purpose statement is "to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality healthcare that meets their needs now and into the future."

[36] HMI Provisional Report, page 139.

9.11 Such devices are just one example of where medical schemes could potentially fund for the health and wellness of their members, towards the better health of the nation. The Scheme requests that the HMI consider this and recommend, in line with the scope of its inquiry which includes the determination of the factors that underlie increases in private healthcare prices and expenditure, that the scope and range of the provision of relevant health services, as defined in the MS Act, be reviewed with consideration of proactive healthcare as well as modern technology and the benefits that it could bring to South African citizens. This amendment not only has the potential to increase the number of participants in the healthcare sector, but also to reduce the burden of disease and reduce the utilisation of healthcare, and so reduce costs.

[redacted]

9.13 DHMS would be happy to engage further with the HMI on this subject.

10. Training of healthcare professionals

The HMI comments on the failure of medical curricula to focus sufficiently on the economic consequences of medical decision-making with regard to investigations and treatment options and the absence of a focus on the need for medical interventions to provide value for patients (irrespective of where the funder is public or private).

10.1 DHMS supports the need for curricula to encompass a thorough understanding of the wider, systemic consequences, as well as the broader individual consequences, of healthcare decision making given finite resources and the potential impact on patients. This understanding needs to be linked to and reinforced by a quality- and outcomes-focused approach to care.

Part II: Responses to Specific Recommendations

11. Governance

The HMI recommends measures to strengthen governance to ensure that schemes place greater pressure on administrators to deliver value to members, that members place greater pressure on schemes to improve value for money, and measures that enable the regulator (the CMS) to exercise more effective oversight over funders.

11.1 DHMS is satisfied that its administrator, Discovery Health, works effectively and efficiently to deliver value to our members, that the Scheme's interests are aligned in terms of offering value to members, and that the fees paid to DH are appropriate and not excessive. This is examined in detail by our Trustees on a regular basis, as set out in more detail in section 4.

11.2 With regards to the CMS' oversight, DHMS has no argument with measures to assist and support the CMS towards improved effectiveness, wherever needed, and notes that the incomplete regulatory framework, together with inconsistent interventions which do not always consider unforeseen consequences, make this a challenge. The Scheme however notes its concerns with the proposed amendments in the MSAAB which vest considerable increased powers in the CMS and the Registrar including but not limited to the powers to unilaterally withdraw scheme benefit options, amend or withdraw scheme rules, and limit non-healthcare expenses (NHE), which we believe may undermine the fiduciary responsibilities of the board of trustees of schemes and place the trustees and scheme members in a position of considerable prejudice (as the latter negates the principles of procedural fairness).

11.3 On investigating whether similar powers are so vested in other legislative arenas with comparable structures in South Africa, and also whether the vesting of powers as proposed in the Amendment Bill is appropriate, it appears that it is not general practice to confer the extensive powers held by the Registrar under the Bill onto a single body such as a Registrar, but rather to centralise these powers in a group of persons or council. It is recommended that the power the Bill gives to the Registrar should be amended and that the powers the Registrar currently holds should perhaps rather be given to the Council to oversee, as this is a group of persons and so will presumably have the scope to be more objective and balanced in its use.

11.4 In addition, the Scheme has appended some information and views regarding the powers of the regulator and principles of good governance for the information and consideration of the HMI. These appendices (D, F, G and H) support our concerns regarding the extended powers of the Regulator and we have also made reference to these in our submission to the NDoH regarding the MSAAB.

Remuneration

The HMI recommends that the remuneration packages of scheme employees, especially trustees and Principal Officers, be linked to scheme performance and that for trustees and Principal Officers remuneration be set at a minimum base level with the remainder of their package linked to clearly-defined quantitative objectives of the scheme. The HMI further supports the implementation of the CMS' proposed framework for capping of trustee and Principal Officer remuneration.

11.5 While DHMS supports the principle of performance-linked remuneration for principal offices and scheme employees, we believe that it is complex and not entirely appropriate to implement for trustees. Similarly, the imposition of caps on Trustee remuneration is also a complex matter and the following factors require consideration in this regard:

- Any caps proposed must be fair and commensurate to the level of risk assumed by individuals.
- We also caution that if caps are set lower than a fair market value, it could negatively impact on the quality of individuals prepared to stand for election or be appointed, as too low a cap will discourage trustees of suitable experience, skills and knowledge.
- Trustees may also not be sufficiently incentivised to perform to the best of their ability.
- Conversely, a cap could be seen as a standard and lead to widespread increases in these costs across the industry.

11.6 In addition, DHMS notes that trustees who serve a limited term may be incentivised to support or propose measures to obtain excellent short term performance by a scheme to the detriment of its long term sustainability, in order to ensure that they receive their full incentive rewards. The Scheme also notes that the CMS has consistently prevented schemes from using performance linked remuneration in contracts with administrators and managed care organisations.

11.7 Please see Appendix B: Trustee Remuneration, section 3, where the Scheme sets out its concerns and a proposed approach that may be able to curtail the issues that are currently faced with regard to the remuneration related risks as highlighted by the HMI.

Annual General Meetings

The HMI makes the following recommendations with regard to Annual General Meetings (AGMs):

That schemes encourage member participation in their AGMs by ensuring adequate representation of members who are not employees, brokers, officers, consultants or contractors of the scheme or its administrator and do not have a material relationship with anyone contracted to or employed by the scheme to provide administrative, marketing, broker or managed care services;
That members must be notified of the scheme AGM in a timely manner and the AGM must be held

at a time convenient for members (e.g. after office hours or on weekends);
That AGMs make use of technology to facilitate participation of members who are not there in person; and
That the CMS review its criteria for election of trustees such that sufficient time and appropriate information is available to members to consider and choose trustees and that electronic election of trustees is possible to avoid abuse of proxy votes. Election of trustees must be conducted over an extended period and completed and audited prior to the confirmation of the election results at the AGM.

11.8 DHMS supports these principles. Please see Appendix C: Trustee Elections for a detailed description of the measures the Scheme has implemented with regards to its elections.

11.9 Deloitte in its 2018 reports states that "DHMS has embraced advances in communication and technology to elicit greater participation by the membership base in the AGMs."

Trustee competencies

The HMI recommends that a set of core competencies for trustees be developed, taking into account the diversity of expertise required.

11.10 DHMS supports the development of a set of guidelines for required knowledge, skills and competencies for schemes to consider in the appointment (as schemes have no control over the knowledge, skills and competencies of elected trustees) and ongoing development of all of their trustees. It is important to remember that different schemes have different requirements in this regard and so schemes must have flexibility in the application of these guidelines. It also may be impractical to train all of a scheme's trustees if such training requires a large time and cost commitment and so such guidelines should be developed in conjunction with all relevant stakeholders.

11.11 Deloitte's 2018 reports note that the "Scheme Rules stipulate that the Board shall ensure that every existing and newly appointed Board Member undergoes Trustee training. The Board Meeting minutes provide evidence of regular briefings on matters relevant to the business of the Scheme. Industry updates are provided at a Committee level". On the topic of training Deloitte concurs that trustee training should be flexible, to meet the needs of the trustees and to remain relevant to the business of the Scheme.

11.12 Deloitte also comments on the annual self-assessments by the Board of the Chairperson, Trustees and overall Board performance and that an evaluation and assessment of the Board was conducted by the Institute of Directors in Southern Africa (IoDSA) in January 2018. These assessments are utilised, inter alia, to identify gaps in knowledge and skills. The IoDSA has facilitated over 240 board appraisals in the last nine years. This database enabled them to benchmark DHMS's performance against that of other NPO entities and DHMS scored higher than the average NPO

benchmark. The IoDSA assessment concluded that the Board has a high level of experience and strong leaders at Committee level.

12. Alternative models of care

The HMI recommends that schemes promote alternative models of care that lower healthcare expenditure. These could include multidisciplinary team care; investing in models of care where appropriate providers provide primary care; re-affirming/strengthening the care co-ordinator role of GPs; investing in innovative forms of care; employing doctors in specific value-based quality-assured managed care service provision, and designing alternative reimbursement models that shift more of the risk of excess utilisation onto providers. The HMI also recommends that the Health Professions Council of South Africa review its ethical rules in various regards, including those that would support the more effective establishment of these models.

12.1 The Scheme supports these models and already works hard to achieve them, with some difficulty given the structural and regulatory barriers as well as contrary incentives present in the market. The HMI's recommendations, if implemented, will be of enormous assistance to DHMS in this regard and are fully supported by DHMS.

12.2 We also request that the HMI recommends urgent action in this regard, as there is potential for direct and immediate benefit to scheme members in terms of the cost of their cover and co-ordination of their care, towards better health outcomes.

12.3 Examples of such initiatives already in operation or in development are mentioned elsewhere in this submission.

13. Benefit design amendments

Base benefit package

To improve transparency and promote competition, the HMI recommends the introduction of a standardised (across all schemes) base benefit package which would include primary and preventative care and incorporate the current PMBs (with extended out of hospital cover, and cover for catastrophic health events). The base benefit package would be common across schemes, must be purchased by all scheme members and must include a system of risk adjustment.

13.1 With the caveat that such a proposal needs to be managed with caution from a competition law perspective, DHMS supports this recommendation, including the inclusion of catastrophic cover and the focus on primary and preventative care, out of hospital cover and increased comparability of a basket of benefits to assist consumers. We also support the recommendation of an associated risk adjustment mechanism and make additional related comments in the sections below.

13.2 We also note the proposal of a Comprehensive Service Benefit Package (CSBP) in the MSAAB. There is a lack of clarity regarding the details of this proposal in the Amendment Bill, which we hope will be further illuminated by the National Department of Health in due course. For example, we cannot tell what is intended to

be included in this package; what the process will be for defining this package and whether or not the CSBP is equivalent to that proposed in the NHI Draft Bill, and/ or overlaps with the HMI's base benefit package proposal. DHMS supports the HMI's recommendations in this regard, and suggests that the HMI's recommendations be adopted in terms of the CSBP.

13.3 We do however caution that with any base benefit package implementation, care will need to be taken to contain standardisation to a level where competition and innovation are not negatively affected and to prevent the further expansion of the related financial burden to members: it should not result in a ballooning of costs beyond what is currently experienced and impact negatively on access to healthcare. We comment further on costs below.

13.4 The Scheme further requests that the HMI consider recommendations to support the extension of cover to low income earners; this vulnerable population would greatly benefit from this and their addition to the risk pool would further the social solidarity principles of the private healthcare framework.

Prescribed Minimum Benefits (PMBs)

With regards to PMBs, the HMI recommends that the PMB package must be reviewed and updated at least every 3 years, and that Schemes must, at a minimum, provide the following information to members:

- *The ICD-10 checklist and plan formulary description for each PMB,*
- *The list of DSPs for the treatment of PMBs, and*
- *During the pre-authorisation process, members should explicitly be told whether their choice of service provider or treatment course has additional cost implications and what alternatives are available.*

The HMI further recommends that treatment plans and formularies will not be binding on schemes, but will constitute a minimum level of care. The development and review of formularies and treatment plans will be run by the proposed Supply Side Regulator for Healthcare (SSRH) in an inclusive, comprehensive and reputable manner.

13.5 DHMS considers it essential that the PMBs are urgently and effectively reviewed and amended to contain escalating costs and ensure the sustainability of schemes, with regular review thereafter. Currently the PMBs amount to a "blank cheque" with limited measures schemes can put into place to contain the associated costs and thus protect our members. DHMS is disappointed and concerned that the HMI appears to not fully recognise the role that PMBs have played in enormously escalating healthcare costs and thus member contributions. This review must take place before the introduction of a new base benefit package, and it is essential for the sustainability of the industry that the review does not simply add to the current PMBs.

13.6 The Scheme supports the inclusion of primary and preventative care in the PMBs, and supports the regular revision of the PMBs so that the revised PMB basket is cost-neutral to the Scheme, and preferably reduces in cost to promote affordability and access to cover. There is a risk, however, that if this process is ineffective or

inadequate the Scheme could be exposed to large increases in claims, particularly if the effective revision does not take place before the implementation of the new base benefit package. Any expansion of PMBs towards primary care should be accompanied by a reduction in high cost, hospicentric elements of the PMBs.

13.7 With reference to the information to be provided, DHMS currently makes formularies and DSP information available to members on the website, or it can be provided on request by the call centre and other contact avenues. In terms of the pre-authorisation processes, DHMS most certainly informs members of this at all opportunities (although we note that pre-authorisation requests often come from hospitals rather than from members directly). DHMS already provides this information to members, and will continue to do so. We are not entirely sure what the HMI is referring to in terms of the "ICD 10 checklist" but note that treating doctors should be providing PMB information to their patients.

13.8 DHMS supports the proposed process for the development and review of treatment plans and formularies.

13.9 DHMS also notes that the HMI did not find PMBs, and in particular the requirement for coverage at cost, to be the primary driver of cost escalation and we note our disagreement with this conclusion as this is not what our analysis has found. We and DH have detailed this to the HMI in previous submissions[37].

Risk Adjustment Mechanism (RAM)

With regards to the RAM, the HMI recommends a mechanism to equalise risk associated with the standard benefit option across all schemes, with lower risk schemes being net payers and higher risk schemes being net receivers from the risk adjustment fund. This mechanism would be initially facilitated by the CMS but eventually migrate to a separate authority with legislated structural independence from any party with a commercial interest in the risk adjustment outcomes (which may include other regulators, the government executive, medical schemes and related parties, healthcare providers, etc.) and to avoid a conflict of interest with the CMS's role.

13.10 DHMS believes that the existence and independent operation of the risk adjustment mechanism is essential, and appropriate to support social solidarity principles. However, it must be carefully and rigorously developed and tested to incorporate both income and risk adjustment to ensure a fair allocation of risk and payments across schemes. The HMI itself has experienced challenges in its attribution analysis and we would expect similar challenges to be experienced in the determination of factors for financial transfers. Such testing should include a thorough analysis of impact on stakeholders and the sustainability and stability of all schemes should be assured. The RAM must also be able to adjust to market developments and changes

[37] DHMS and DH Submission To The Competition Commission Health Market Inquiry On Reports Published In December 2017, 28 February 2018 ; Discovery Health Submission: Competition Commission market inquiry into the private health sector, November 2014

over time, so that levels of compensation for various groups and the underlying risk of those groups does not become disconnected.

13.11 We also believe that the introduction of a phased mandatory membership would support the development of stable risk pools, and comment further on anti-selection measures below.

13.12 The HMI further states that a database of all insured beneficiaries and the relevant demographic information to determine the prospective risk status of each beneficiary must be developed and maintained by CMS for the purposes of operating the RAM.

13.13 DHMS recognises the need for such information to operate the RAM, and supports the development of a database, or alternately a decentralised alternative mechanism for accessing the relevant information, in this regard but with the condition that member privacy must be absolutely maintained within the requirements of all relevant legislation, and the obligations of trustees to protect member information. Adequate information security is also essential.

13.14 Information to be contained in the RAM database should be defined in consultation with stakeholders to ensure such protection. The Scheme also notes that the MSA Amendment Bill proposes extended powers to be delegated to the Council for Medical Schemes, including that of establishing a beneficiary register and central register of Health Care Providers and health care establishments. While we agree with the HMI regarding the importance of information in healthcare we note that the costs and risks involved must be proportional to the benefits received, and that a co-ordinated approach to reviewing the requirements of the various systems proposed holistically should be taken to ensure that there is no overlap or duplication, and also that information requests are linked to a specific purpose as well as cost and appropriateness assessments. Explicit provisions are necessary to ensure the protection of personal information, requirements for security of member data, that the processing of personal information only be undertaken if it is adequate, relevant and not excessive (the condition of minimality[38]) and so on. The Scheme has attached a report regarding the role of information for regulators which examines the proposals made in the HMI Report, the MSA Amendment Bill and the NHI Draft Bill in the light of good regulatory practices as Appendix E for the information and consideration of the HMI.

[38] In accordance with the Protection of Personal Information Act, 2013, s10, and the Caldicott principles as followed by the UK's NHS (see https://www.salisbury.nhs.uk/AboutUs/OurPoliciesAndProcudures/Documents/Appendix%20D%20V2.1.pdf)

The HMI recommends that to address the needs of low-income scheme members the current tax credits be reconstituted to take the form of a contribution subsidy administered through the RAM rather than though the South African Revenue Services in order to support principles of risk and income adjustment.

13.15 The Scheme supports mechanisms to promote access to healthcare for lower-income members, and recommends that low cost benefit options be revisited for introduction in this regard.

13.16 While we support the principle of a contribution subsidy as proposed, the implementation of such changes needs to be carefully considered in terms of sequencing and of safeguarding against the inadvertent removal or reduction of cover for some members. The Scheme observes that on some of our plans, like KeyCare for example, a large percentage of contributions are covered by tax credits and so reducing these in any way will directly impact on access for lower income earners[39].

Supplementary cover

The HMI recommends that schemes be able to offer supplementary benefit options for which members may be risk rated provided the base benefit package is sufficiently comprehensive.

13.17 DHMS has following notes and reservations regarding this recommendation:

13.18 An assessment of what comprises sufficient comprehensiveness of the base package must be reached through a process of engaging all industry stakeholders. There is a risk that supplementary cover may become unaffordable for high risk, low income members in need of it if the inclusions in the base benefit package are inappropriate, and on the other hand that the base package would be too expensive for low income consumers if it is too extensive: while the RAM will address the spread of costs, it will not address the overall level of costs as the CSBP will determine the minimum cost of cover.

13.19 Schemes should not be restricted in the variations of supplementary benefit options they are able to offer, in order to not dampen competition or innovation, as long as such offerings align with the greater policy framework requirements (in this case the NHI – and given that the NHI policy is not yet settled, it would be premature to include specific provisions in the MSAAB to do so, as these may later turn out to be non-aligned or even contradictory). The Scheme has appended some information and views regarding the powers of the regulator as proposed in the MSAAB, including to unilaterally restrict benefits without consultation with medical schemes. This appendix makes the points that this amendment allows for the unequal treatment of schemes; goes beyond what is necessary to achieve alignment with the NHI; is

[39] On the lowest income bands on KeyCare (i.e. those families earning between R0 and R8551 a month) across all KeyCare options, the tax credit subsidises 35.1% of contributions. This ranges from 34.8% on KeyCare Plus to 46.1% on KeyCare Access. These figures are for 2018.

disproportionate; and inconsistent with the principles of good regulation. Such intervention would also require procedural safeguards to ensure that negative effects are avoided and a proper consultative process should be specified. We attach Appendix F in this regard for the information and consideration of the HMI and note that the same principles apply to the proposed amendments in the MSAAB to allow the Registrar to unilaterally amend scheme rules.

13.20 The possibility of negative effects are exacerbated by the proposed wording in the MSAAB which cancels the suspensive effect of lodging an appeal on the decision being appealed against and which could result in an incorrect, random or arbitrary implementation of changes having detrimental effect to schemes, members and/ or the industry as a whole. DHMS has experienced several instances where the Registrar has erred in his interpretation of the Act and / or Regulations, and made decisions binding on DHMS in the process, but the current appeals process has protected the Scheme and its members in these instances and should be retained.

13.21 We note that the NHI Bill, while currently unclear, may impose a complementary model on medical schemes which may restrict our ability to provide parallel cover. We believe that there are other models which, while completely aligned with the objectives of the NHI, are not overly restrictive and also assist to ease demand on the public healthcare system. International experience shows that a complementary model is highly unusual and that a hybrid model is more likely to be beneficial[40], while not overly restricting freedom of choice by consumers. DHMS also recommends that a more robust assessment of the various models proposed take place before the finalisation of policy in this regard.

13.22 In this regard we also note that parallel private health insurance cover would not compromise, and in fact would provide relief to the public (NHI) Fund as consumers would still be obliged to make mandatory NHI Fund contributions, but at the same time being afforded their constitutional right to purchase additional private healthcare cover should they be able to afford it.

13.23 In the case of DHMS and other large open schemes, our member body represents significant variation across health status, issues and disposable income and the ability to attract a large spectrum of members through the ability to offer appropriate supplementary cover is a pro-competitive mechanism whereas limiting supplementary cover options may constrain the rights of consumers to purchase private cover. In this regard DHMS would support the development of a presentation format applicable across the industry which would support both the broker community in advising their clients appropriately as well as individual consumers to identify an option that matches their needs.

[40] Harris, P. (2017) Access to healthcare in South Africa and the proposed NHI Plan, Submission to the High Level Panel

14. Review of solvency requirements

14.1 DHMS agrees with the HMI's statement that solvency requirements provide a safeguard for scheme members, and its position that solvency requirements should be reviewed, but notes that specific recommendations for this were not included. DHMS reserves its right to comment on the solvency proposal (once articulated by the HMI).

14.2 We believe that a risk-based capital approach should be used, which will impact positively on the cost of contributions for our members through more efficient capital employment, and look forward to the HMI's recommendations in the final Report.

15. Anti-selection measures

The HMI states that it is uncertain as to whether the current legal provisions against adverse selection (waiting periods and late joiner penalties) offset the financial implications of anti-selection.
The HMI therefore only recommends that an incentive to encourage younger joiners be introduced and further suggests that this incentive could take the form of a regulated discount for joiners younger than 35, and that this discount could be determined by the Minister of Health in consultation with the CMS.

15.1 DHMS refers the HMI to a submission[41] made by DHMS and DH, which contains detailed and compelling analysis regarding the inadequacy of the current legal provisions in this regard.

15.2 DHMS's view is that if younger consumers see private healthcare insurance as non-essential, it is unlikely that a small discount would entice them to join. The discount would have to therefore be sufficiently large to counterbalance a tendency to resist this expenditure at all.

15.3 We note that the cost of this proposed discount for young adults will be borne by older members, thereby eroding part of current risk cross-subsidy. Further, tighter underwriting should accompany this provision, discouraging younger adults from merely exiting the scheme once they no longer are eligible for the discount and re-entering when they require cover. Extended underwriting may also be needed (separately or in conjunction with) to further protect the risk pool from late joiners who tend to claim more. Ideally, mandatory membership for consumers earning above a defined threshold would safeguard members of all schemes in this regard.

15.4 Overall, a scheme's decision on whether to implement underwriting measures available to it arise from its need to maintain the stability of its risk pool in the absence of compensating regulatory protection. Open medical schemes are operating in a regulatory environment that has open enrolment and community rating with limited opportunities to protect the risk pool from anti-selection. The intention of open

[41] "Discovery Health and Discovery Health Medical Scheme response to Health Market Inquiry request for input on the need for and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition", January 2018

schemes imposing underwriting when members have the opportunity to select to change their cover based on their health status is to protect the risk pool from anti-selection and hence preserve affordability. A risk equalisation mechanism, along with mandatory membership, would address this challenge and eliminate the need for underwriting.

15.5 It is of concern to the Scheme that the MSA Amendment Bill proposes weakening the measures that enable schemes to mitigate the risk of anti-selection and to underwrite effectively, and we believe that implementing its proposals will be highly detrimental to the sustainability of the medical schemes industry and directly cause several percentage points of contribution increases, thereby forcing members out of the system. We can provide the HMI with more information and analysis regarding the value of waiting periods on request.

The HMI states that non-risk benefits should not attract any waiting periods as schemes do not bear any risk for any claims paid from non- risk benefits.

15.6 The HMI is incorrect in stating that MSAs do not carry risk for the Scheme. The full annual amount of the MSA is assigned to members at the start of the year, although the member has not yet contributed the amounts into Scheme funds (so it is made available to the member as a quasi "credit" facility). This means that if a member utilises their MSA funds in the first six months of the year, and then exits the Scheme, the Scheme must attempt to claw back the funds from the member. This is particularly complicated if the member has exhausted their MSA funds and started to use their Above Threshold Benefit ("ATB"), which is paid from risk. MSA claims accumulate towards the ATB from the start of the year and so members effectively may have access to risk claims during their waiting periods. The Scheme therefore may correctly decline PMB-related claims during waiting periods, but this is dependent on the specific underwriting category of the member.

The HMI states that it supports the principle of mandatory membership, but does not believe that it is beneficial to introduce into the current flawed system.

15.7 DHMS understands this view but nevertheless believes that for the principles of social solidarity to be truly functional, mandatory membership is absolutely necessary. We therefore request that the HMI includes in its final report recommendations for when and under which conditions mandatory membership should be introduced. We also request that further consideration is given to the phased introduction of mandatory membership by income bands at this point; the implementation of the HMI's other recommendations should sufficiently mitigate the risk entailed and therefore the introduction of mandatory membership could be contingent on the implementation of other measures first.

15.8 The Scheme welcomes the acknowledgement by the HMI that in the absence of mandatory membership, stricter underwriting may be necessary to mitigate against anti-selection. The Scheme proposes that the HMI includes this observation on as part

of their recommendations with suggestions on how underwriting could be strengthened and the risk pool sustained.

15.9 In general, DHMS is greatly concerned that the HMI seems to have understated the effect and impact of anti-selection on the industry, and urges and requests the reconsideration of this stance, and the recommendation of stronger regulatory measures to reduce anti-selection.

16. Brokers

The HMI recommends that the interaction between members and advisers be a transparent, active opt-in relationship, annually renewed by member declaration, and that members who choose to not use a broker will pay contribution rates less broker fees.

16.1 DHMS supports transparency of the broker-member relationship and fees paid, and appreciates the HMI's acknowledgement of the importance of the brokers' advisory role. The Scheme views this role as so important that it would by preference support measures to actively grow member awareness of the value that brokers offer to them, and to encourage their use; an unintended consequence of the HMI's recommendations may be that members, in order to reduce their expenditure, choose to not use a broker without taking into account the possible implications of making less informed plan choices. Brokers are in the best position to offer unbiased advice when choosing a scheme or a plan, and this function cannot be performed by an administrator or a scheme. Brokers not only support the choice of plans that are suitable to their healthcare needs and economic circumstances by members, but also assist members with ongoing support in resolving queries and claims when necessary. Healthcare is inherently complex and difficult to navigate and brokers can provide members with invaluable support through their personal relationships with members. Some analysis of DHMS members who do not have an active broker shows that such members have significantly lower plan movements compared to members with active brokers. In January 2017 2.0% of these members changed their plans versus 3.4% for members with brokers (and versus 3.7% for members with a corporate broker). This indicates the importance of the role of brokers in assisting members to understand the ongoing relevance and appropriateness of their plan choice to their needs.

16.2 While supporting transparency of broker fees, DHMS recommends that broker consent and payment processes be pragmatic. For example, it is simply not pragmatic or feasible to require that each individual employee in a company provide consent once an employer appoints a broker.

16.3 In addition DHMS recommends that once a member has given consent, this consent should remain valid unless the member opts out, which they should be free to do at any time.

16.4 The Scheme notes the proposed changes in the Medical Schemes Amendment Bill regarding brokers, with some overlap with the recommendations made by the HMI including an explicit opt-in choice by members, and again we comment that this process needs to be pragmatic. The MSAAB appears to make provision for the

continued payment processes to flow through the schemes (in its requirements regarding a contribution table) which DHMS supports. In terms of the MSAAB, it is also of concern that there is a lack of clarity around certain definitions, and in terms of regulations that seem likely to need changing as a result of the proposed amendments.

17. Publishing comparative data

The HMI recommends that the Council for Medical Schemes produces a biennial report on the value of managed care services including the extent to which risks and benefits are shared between contracting parties and how savings are passed on to scheme members by lowered premiums or increased range of benefits. The HMI further recommends that the CMS publish administrators' comparative performance on metrics such as non-healthcare costs; the value of PPNs, DSPs and ARMs, claims payment ratio, and the proportion of PMB and non-PMB claims paid from risk versus those paid from savings be published annually for each administrator compared to a national average. This publication should be produced by the CMS.

17.1 DHMS would welcome such a publication for its value to industry members and consumers. However, we must caution that this type of reporting is highly complex and that given the variation in how business is conducted throughout the industry, it is very challenging to compare apples with apples and we believe that the analysis should also be done by individual schemes to account for the differences in benefit structures and contracting with administrators, and/or recommend that a process of industry standardisation to develop consistency about classification is undergone, in a consultative process with stakeholders. The HMI's own experience with the difficulties entailed in isolating the causes of various effects is reflective of this challenge.

17.2 In agreement with this view, Deloitte in their 2018 reports comment: "Performing a comparison between schemes on administration fees or value adding services can be quite challenging. Published data will be dependent on the specific scheme's understanding of the requirements of the data and the manner in which data is presented and captured. Industry wide reports can performance metrics such as healthcare costs, the value of Alternative Reimbursement Model or Provider Network can be highly complex with unintended variations in the published data."

17.3 We note that our own work done over several years to calculate the value added by our administrator to DHMS, as has been extensively detailed to the HMI, is something that could facilitate the comparison of administrators and that we would support such an industry-wide adoption of a similar approach.

17.4 DHMS also notes that the MSA Amendment Bill contains changes which impose the reporting requirements of the CMS in terms of the Public Finance Management Act No. 1 of 1999. The requirements appear to include the submission of an annual report and audited financial statements and the submission of these to the executive authority of the CMS, and the tabling of these in Parliament or the provincial legislature. It is, however, somewhat unclear if the requirement for the CMS to publish

its annual report would still be in force. The Scheme's concern in this regard is that the annual report as currently published by the CMS is very valuable to the industry as it provides an industry overview and assessment, and is a critical input into the analysis that DHMS conducts each year to assess its own performance relative to the industry as well as to benchmark administration expenses paid by the Scheme to Discovery Health against those of other open schemes. The Scheme recommends that the CMS should continue to publish the report in this format, and that it consider the additional reporting that the HMI recommends to be as per our comments above.

18. Market entry and competition

The HMI recommends that the CMS facilitate the entry of regionally-based schemes by allowing reinsurance for such schemes.

18.1 DHMS believes that robust competition in any market produces better outcomes for consumers and so supports any fair measures to support competition, subject to such measures not creating instability in the industry. DHMS requests that the HMI provide further clarity regarding this recommendation and the reasons for it in order that we are able to comment more fully.

18.2 We also note that as mentioned elsewhere in this submission, the regulatory framework is a challenge for new entrants due to the process of registering a scheme, as well as the capital requirements of new entry.

19. Supply Side Regulator of Healthcare, facility licencing and tariff setting

The HMI identifies several failures in the supply side of the healthcare market and proposes the establishment of a supply side regulator (SSRH) having four key functions: health capacity planning (including the implementation of a centralised national licencing framework for all health establishments and the management of practice codes); economic value assessments; implementation of appropriate pricing mechanisms; and outcome measurement, registration and reporting (in partnership with the OMRO).

Supply side regulation

19.1 The Scheme supports the need for supply side regulation; however the proposed SSRH structure is complex and so further work is required to develop an appropriate framework.

19.2 We have appended a piece regarding principles of good regulation as Appendix G for the information and consideration of the HMI, as the HMI may wish to consider these principles in developing its final recommendations regarding the SSRH and with regards to other regulatory principles.

19.3 The HMI proposes that one of the critical pillars of supply side regulation is economic value assessments, and recommends that this work be carried out under the auspices of the SSRH. DHMS supports the need for such assessments and welcomes the HMI's recommendations in this regard, including the publishing of findings. We also note

that the Socio-Economic Impact Assessment System (SEIAS) report relating to the MSAAB does not appear to be supported by an economic value assessment of any substance and that the report states "There is a clear understanding of the cost implications of the proposed legislation and no additional research is therefore indicated at this time." This is concerning and the Scheme believes that at the very least, an assessment of the impact to affordability should be conducted. Robust regulatory impact assessments comparing regulations against the likely counterfactual in terms of costs and benefits should be used to inform decision-making and to assure regulatory quality[42]. An impact assessment is standard practice by regulators in other jurisdictions and sectors prior to the imposition of any form of regulation[43].

Facility licencing

19.4 The Scheme supports the proposed amendments to the facility licencing regime and believes that such amendments will support the establishment of improved quality outcomes as well as assist to manage the supply side factors driving utilisation.

The HMI has considered various options in its report for addressing its finding regarding hospital concentration, including divestiture and a moratorium on licences for the three large hospital groups.

19.5 The Scheme suggests that the HMI place more focus on measures such as detailed assessment of need as well as compliance with reporting requirements for hospital licencing, which coupled with an increase in ARMs and a focus on quality will be more effective than blunt measures of restricting market shares to improve competition.

Pricing mechanisms

The HMI makes various recommendations regarding tariff determination processes.

19.6 As a starting point, DHMS notes that any pricing mechanism will need to be formulated within the framework of the Competition Act and managed through appropriate mechanisms, exemptions or otherwise.

19.7 In order to test the correctness of our understanding of these recommendations we reflect them in paragraphs 19.8-19.13 below, and thereafter provide our comments based on this understanding. If we are mistaken on any points we request the HMI to clarify in their Final Report.

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[42] *Source: OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 4*

[43] Source: Ofcom (2005) Ofcom's approach to Impact Assessment, p. 3 and NERSA Survey for the Regulatory Impact Assessment of Tariff Methodologies - Petroleum Pipelines Industry

19.8 The Scheme's understanding is that the HMI's recommendations in terms of the tariff determination process seek to strike a balance between anti-competitive collective negotiation, and unilateral price setting by a regulator without levels of stakeholder engagement. The HMI's proposal includes both a forum for setting prices on a multilateral basis as well as bilateral negotiations.

19.9 The HMI proposes two different approaches for the determination of tariffs:

19.9.1 The regulatory solution with multilateral inputs. Under this solution, the SSRH will receive submissions simultaneously from stakeholders, which will serve as a basis for setting the FFS tariffs. The tariff will be determined and published by the SSRH. Guidelines are required by the HPCSA and SSRH which sets out clearly what might constitute unethical billing.

19.9.2 A multilateral price setting mechanism where the tariffs are negotiated amongst stakeholders, but under a framework determined by the SSRH. The SSRH will issue guidelines for the negotiations, specifying rules and conditions (for example, maximum allowed increases). The final PMB and reference prices must be published by the SSRH, the CMS, funders and service providers.

19.10 Under both approaches, it is proposed that FFS tariffs related to PMBs are binding, without any balance-billing or co-payment allowed. In this way, it sets a maximum price for PMBs.

19.11 FFS tariffs for non-PMB services will have the status of reference prices. These tariffs may only be exceeded if the practitioner secures consent from the patient, or if higher outcomes are negotiated with the funder.

19.12 Failure to reach agreement under both proposals would be resolved through a compulsory arbitration mechanism. The arbitrator is independent and the decision made will be binding.

19.13 The HMI supports bilateral negotiations between funders and corporate providers, particularly for the purpose of transitioning from FFS to ARMs. Performance-based contracts, which deal with transfer of risk, can only be negotiated bilaterally between funders and each provider.

19.14 The HMI's recommendations with respect to tariff negotiations are supported by DHMS at the principle level. In particular:

19.14.1 Encouraging bilateral negotiations between funders and corporate providers, including hospitals and pathology is important for competition.

- Bilateral bargaining promotes competition between providers and improves the negotiating position of schemes. The ability of schemes to direct patients to alternative providers is an important source of bargaining power for schemes.
- Further, the means to introduce ARMs and other innovations aimed at addressing utilisation and efficiency is critical, as costs do not just depend on the price charged by providers, but also utilisation. This can only be achieved through bilateral negotiations, as recognised by the HMI.

19.14.2 The determination of maximum tariffs for PMBs for practitioners is fully supported and deals directly with the imbalance in bargaining as a result of the requirement for funders to cover PMBs in full. This requirement

impedes the ability of funders to price negotiate. DHMS also supports the proposal that providers be prohibited from balance billing for PMBs.

19.15 We do however seek further clarity from the HMI with regards to the following areas where we feel there is some ambiguity:

19.15.1 The HMI refers to FFS under the multilateral framework and ARMs under the bilateral negotiating process. However, it should be made explicit that bilateral negotiations with corporate providers should be the mode of price-setting for both FFS and ARMs. The proposal by the HMI should not prevent DHMS and DH from negotiating FFS tariffs bilaterally with corporate providers.

19.15.2 The recommendations made by the HMI in respect of price setting proposals do not distinguish between corporate providers and practitioners.

- DHMS supports the multilateral tariff setting approach with respect to practitioners, as one-on-one negotiations between funders and individual practitioners are not practical and the practice has been for practitioners to set their rates unilaterally.
- It is, however, different with respect to corporate providers, as bilateral negotiations are possible and the transaction costs of doing so are not large. Therefore, proper consideration must be had regarding the tariff determination for corporate providers to ensure that any negative unintended consequences are avoided and competition between providers is promoted. The HMI's recommendations should not impede the ability of DHMS and DH to negotiate bilaterally with corporate providers and in particular, the ability to negotiate ARMs which is critical for bringing down costs for members.

19.16 In terms of the two proposals put forward (the "regulated approach" and the "negotiated approach"), the HMI has not indicated how this will be decided going forward. DHMS favours the negotiated multilateral approach.

19.16.1 Regulating prices is one of the most intrusive forms of regulatory interventions. Allowing for multilateral negotiations between providers and funders is less interventionist and would allow the relevant market players to determine prices, within the relevant framework and rules set by the regulator. When designing regulations that are proportionate, it is important to consider all of the options that are available for achieving the particular policy objective, including a consideration of which option involves the least burden of effort and cost.

19.16.2 A key objective of DHMS is to lower the healthcare costs for its members, while not compromising the quality of care they receive, or available supply. This involves a balanced, careful consideration of tariffs to ensure that members have access to quality of care, but are not charged excessively. Funders are well-placed to engage in this balancing exercise as this is core to their role and aligned with their mandate.

19.16.3 A negotiated approach is also a more pragmatic approach as the determination of tariffs is complex and technical. Funders have already

developed the technical expertise to engage with providers. In contrast, the SSRH is yet to be established, has no technical capacity or baseline experience on how to set prices in health care which would only be developed over time.

19.16.4 Even within the negotiated approach, however, the SSRH would have an important role, not only to determine the framework and rules, but also in its capacity to request additional information from stakeholders to support the process of tariff negotiations. This is particularly important given the information asymmetry between providers and funders. The SSRH would need to ensure that the inputs for the multilateral bargaining process are rigorous and trusted.

19.16.5 DHMS also supports the appointment of an independent arbitrator. It is important, however, that the arbitrator has specialist knowledge and is technically skilled to be able to make an informed decision.

19.17 Finally, regardless of the proposal chosen for determining tariffs, there are several important factors that will need to be considered to ensure that they are set properly in a manner that avoids unintended consequences.

19.17.1 The importance of setting appropriate tariffs. To achieve the objectives of lowering costs without compromising availability of supply and quality of care, it is critical to get the price level right, as this will have an impact on supply conditions. This is especially in respect of PMBs, where the tariff is binding, but also for the non-PMBs where the tariff will be used as a reference price and therefore has some significance, especially for consumers. When a tariff is binding or effectively binding, it will have a real effect on the income and investment decisions of providers.

19.17.2 The determination of tariffs is not a trivial exercise. A high degree of care and precision will need to go into the accurate determination of tariffs, with consideration of all stakeholders to ensure the sustainability of the entire system. If the tariffs are set too low, this will impact negatively on the viability of health care providers and their ability to invest. This in turn will likely have a negative impact on access to healthcare services by members, including quality of care. Conversely, where the tariff is set too high, the risk is that members will be charged excessively high fees.

19.17.3 Pricing mechanisms should consider costs, including variation amongst providers. The price paid for healthcare products and services should be reflective of the costs involved in the provision of services. Under this approach, a proper application would require the determination of an appropriate cost model for providers.

19.17.4 This exercise is complicated by the variation in costs amongst providers. By way of illustration, the HMI notes that there are 4 893 medical specialists, and 13 593 general practitioners – there are many reasons why costs will vary amongst this large group of practitioners, even for the same type of procedure. For example, costs will depend on:

- The location of the medical practice under review;

- The use of specialised medical equipment within the medical practice;
- Whether the medical practitioner is a sole practitioner or in a partnership;
- The level of skill and experience of the medical practitioner, and
- The patient's specific needs.

19.17.5 Since different fees could legitimately be charged by practitioners, the pricing mechanism would need to recognise this to avoid unintended consequences associated with inappropriately set tariff levels.

19.17.6 The determination of tariffs initially will be an enormous exercise, as there is no existing reference tariff as a starting point. The degree of complexity is reinforced by the large number of procedure codes, as was reflected in the determination of the National Heath Reference Pricing List. Once tariffs have been determined for the base year, the regulator would need to consider how to adjust these going forward. The practice in South Africa in respect of reference price lists has been to adjust tariffs annually by a percentage increase that is linked to the inflation rate.

19.17.7 An important consideration for a regulator is whether it is appropriate to adjust by inflation (and if so, which rate should be applied as inflation for health services diverges from CPI), but also whether there should be an adjustment for efficiencies each year. This approach is referred to incentive regulation because it provides strong incentives for the providers to improve efficiency in order to profit from the price adjustment. Any adjustment to drive efficiency will also need to be considered carefully if a regulator is to avoid setting a price increase that is either too generous or too stringent: A downside error on price adjustments (i.e. a price that is too stringent) poses particular concerns as it is likely to result in the reduction of output and investment by the healthcare providers. An upside error is also a concern as it results in consumers paying excessively high prices.

19.18 While the HMI's recommendations on tariffs is largely focused on FFS tariffs determined in a multilateral context, the promotion of ARMs must remain a priority.

19.18.1 DHMS is taking a lead in promoting ARMs, and in particular, championing the use of integrated, multidisciplinary care. This reflects the desire to move away from FFS, which largely rewards quantity, but not the quality and efficiency of outcomes. In contrast to FFS, multidisciplinary models of care focus on rewarding value. With this approach, care around a condition or set of related conditions is provided by multidisciplinary teams in dedicated facilities. Bundled payments are made that cover all costs of care to treat a condition, where payment is linked to delivering good outcomes and is adjusted for risk[44].

19.18.2 The HPSCA regulations largely prevent such models from emerging, with the HMI recognising that the HPCSA regulations prevent innovative contracting and the formulation of multidisciplinary models of care. Any

[44] Porter, M.E. and R.S. Kaplan (2016) "How to pay for Health Care", Harvard Business Review (July-August 2016)

consideration of tariffs therefore needs to start with a review of the HPCSA ethical rules to allow for multidisciplinary practices and global fees, as recommended by the HMI.

19.19 While DHMS supports the HMI recommendations, the implementation thereof is critical. The recommendations should not impede the ability of funders to engage in bilateral negotiations with corporate providers as this is pro-competitive. Where tariffs are to be determined on a multilateral basis, careful thought needs to go into how this is done, given the complexities described above. A robust consultative process amongst all stakeholders is required to ensure that any regulations produce the intended result and avoid unintended consequences.

19.20 We include as Appendix I some information on price and cost determination from an international perspective and with reference to National Health Insurance and the operations of the Fund, but which may also be relevant to the HMI's recommendations and views in this regard.

20. Outcomes measurement and reporting

The HMI recommends the establishment of an outcomes measurement reporting system, with the establishment of an independent statutory entity, titled for the interim the Outcome Measurement and Reporting Organisation (OMRO), to oversee the system in phase two of its establishment.

20.1 The Scheme supports this focus on quality measurement and reporting, and is hopeful that the HMI's recommendations will support industry work in this regard. We support the establishment of the OMRO and support the HMI's recommendation that it be completely independent. Independence and an apolitical stance is vital for its credibility.

20.2 We do believe, however, that investment from stakeholders in terms of expertise and collaboration is required for the establishment of a credible authority and that there is an opportunity to leverage off existing initiatives such as the Health Quality Assessment ("HQA") rather than starting from scratch. We also note the HMI's proposal that the initial phase of the OMRO should be funded by providers and funders, prior to a suitable long term funding mechanism being established. We caution that a pragmatic approach should be taken to balancing investment with value to consumers and that an inclusive stakeholder engagement approach must be taken to reaching agreement on the way forward in this regard.

20.3 We would also welcome the early inclusion of structure, process and experience indicators into the process, as work in some of these areas is already progressing well and could form a useful base. While process indicators are very well-established, structure and experience indicator collection is not yet prevalent in the industry – but we believe all of these to be relevant and important.

20.4 We believe that it is also very important to have a standardised base across both public and private sectors, and note that some work is already underway by the HQA to collaborate with the public sector.

20.5 We also note that funders are engaged in various initiatives of their own in terms of quality towards better outcomes and member engagement, which are pro-competitive in the sense that they differentiate funders. We suggest that consideration is given to structures and reporting that retain this differentiation and facilitate consumer comparison between funders, while providing comprehensive information across the industry.

21. HPCSA rules revisions

The HMI recommends that the HPCSA revise its ethical rules, particularly with regards to competition aspects and enabling group practices and global fees, including fee sharing under appropriate circumstances; multi-disciplinary practices; and employment of doctors under certain conditions.

21.1 The Scheme supports the HMI's recommendations in this regard and believes that the HMI's encouragement for the industry to adopt ARMs, as well as to consider alternative models of practitioner employment, has the potential to benefit the industry enormously and to promote innovation.

21.2 The Scheme also notes the HMI's comments in the Report regarding the inadequate penalties applied by the HPCSA for unethical conduct, and the need for an intervention to bolster capacity and/ or increase oversight by the NDoH in this regard. In DHMS's view the level of penalties applied by the HPCSA have been inadequate to deter similar future behaviour and are perceived to be nothing more than a slap on the wrist. Our experience also shows that the process followed by the HPCSA is extremely slow and we have some cases that have been outstanding for over ten years. We request that the HMI consider making specific recommendations in this regard, as our work to deter and reduce fraud, which has serious financial implications for our members, would be greatly supported by improvements in this area. The Scheme would be happy to engage with the HMI and provide more detail in this regard.

22. In closing

22.1 In closing, we would like to reiterate how important we believe the correct sequencing of reforms and the inclusion of all of the relevant components are to ensure the effective functioning of the entire private healthcare system, and to ensure its functioning as a parallel system to public healthcare in a way that is supportive of public health. We look forward to a collaborative and inclusive stakeholder process to address the sequencing and other implementation challenges.

22.2 The Scheme hopes that the HMI's many positive recommendations towards industry improvements will be supported by appropriate amendments to the Medical Schemes Act in the final Amendment Bill to be published by the National Department of Health, most particularly with regards to addressing the current regulatory gaps which currently impose system risk and instability, to the ultimate cost of consumers. We would be happy to share our submissions on the Medical Schemes Act Amendment Bill and National Health Insurance Draft Bill with the HMI.

22.3 We welcome further questions from and opportunities to provide more information and analysis to the HMI wherever it may be required, and would like to thank the HMI for its consideration of our submission.

Appendix A: DHMS growth per annum

The table below illustrates the small percentage by which DHMS's growth can be attributed to amalgamations (as opposed to organic growth).

The Scheme's average net rate of growth of beneficiaries from 2000-2017 was 9.7% including and 9.6% excluding amalgamations per annum, and from 2009-2017 it was 4.0% including and 3.9% excluding amalgamations per annum. It is therefore clear that only a fairly small portion of the annual growth of the Scheme has been due to amalgamations.

Year	Beneficiary Growth	Beneficiary Growth (excl. Amalgamations)
2000 - 2001	42.1%	42.1%
2001 - 2002	23.1%	23.1%
2002 - 2003	21.5%	21.5%
2003 - 2004	21.1%	20.0%
2004 - 2005	13.0%	13.0%
2005 - 2006	9.9%	9.9%
2006 - 2007	3.6%	3.6%
2007 - 2008	2.6%	2.6%
2008 - 2009	3.7%	3.7%
2009 - 2010	8.7%	8.2%
2010 - 2011	6.1%	6.1%
2011 - 2012	4.9%	4.7%
2012 - 2013	4.4%	4.2%
2013 - 2014	3.0%	2.8%
2014 - 2015	2.5%	2.5%
2015 - 2016	1.7%	1.7%
2016 - 2017	1.6%	1.6%

Appendix B: Trustee remuneration

1. It should be taken into account that trustees are required to assume risks which include general business risk, the risks of litigation, compliance, etc. and it is therefore important to be cognisant of the fact that remuneration must be commensurate to attracting, retaining and investing in the correct skills and people.

2. In addition the remuneration to be earned must take into account the level of risk that trustees are required to assume. Other factors that will have an effect on the level or remuneration paid to trustees, include:
   2.1 The size of the Scheme;
   2.2 The level of expertise and skill required by Boards
   2.3 The type of skills and expertise that the Board wishes to attract
   2.4 The complexity and industry dynamics of the private healthcare industry
   2.5 The complexity of managed healthcare delivery interventions and multiple tiers of Scheme operational management
   2.6 The competitive positioning of Schemes.

3. Performance agreements and performance based remuneration

3.1 It is submitted that concluding performance agreements with trustees and committee members may not be appropriate as the duties of trustees differ from those of executive officers, whose duties may be enumerated into tangible actions and performance measures.

3.2 Penalising the Board of Trustees by remuneration for non-performance may not be appropriate and that non-performance could be addressed through robust governance structure including measures such as ongoing training and development, peer reviews and self-reviews.

3.3 The ultimate test of performance of the Board would be the performance of the Scheme and the achievement of the Scheme's strategic objectives. The chairperson of the Board and other non-executive trustees should not receive incentives geared to Scheme performance as such incentives align their interests too closely with executives and may be seen to impair their objectivity.

3.4 Remuneration penalties may not be appropriate for trustees and underperformance by trustees may be best addressed by the creation of appropriate robust governance structures.

3.5 The linking of performance objectives for trustees to quarterly and annual goals is also problematic, since the trustees, like directors should have a longer term view and the goals of the Board are more likely to be longer term goals which cannot be addressed through remuneration in the immediate term. A practice which could support the CMS's view is the payment of Board remuneration quarterly in arrears to encourage and motivate performance throughout the quarter

3.6 External performance assessments may not be relevant but an external review of the Board's performance, could be appropriate to inform Boards of certain shortcomings and areas for development and improvement.

4. King IV principles

4.1 The implementation of King IV Principles will not completely address the issue of inconsistent remuneration provisions, but it will go a long way to enable each Scheme to implement a remuneration strategy with levels of remunerations which will be appropriate to the requirements of the respective scheme.

4.2 The implementation of King IV principles will also ensure public accountability and transparency.

4.3 The adoption of King IV principles in respect of the remuneration of trustees would assist schemes in implementing a remuneration framework and policy for trustees.

4.4 Proper application of the King IV principles and recommendations will address the CMS' concerns regarding inappropriate corporate governance in relation to Trustee remuneration.

4.5 It is therefore recommended that all schemes implement robust governance structures including the establishment of a Remuneration Committee for purposes of informing its remuneration strategy, policy and level of remuneration. The Remuneration Committee should be balanced with independent representation and scheme trustees. The Remuneration Committee should be able to rely on independent expertise through the use of contracted services to provide for example independent benchmarking and reports to the Committee.

5. Disclosure of Remuneration

5.1 Schemes should be required to have a remuneration policy which sets out how trustees and independent board committee members are remunerated, which policy should be disclosed in the scheme's integrated report and tabled at their AGMs for a non-binding advisory vote and that trustee remuneration should be approved at the scheme's AGM each year. These should be provisions that must be incorporated into a Scheme's rules.

5.2 In order to facilitate transparency and reporting of trustee remuneration to the industry and members of the scheme, schemes should disclose annually, the total cost of board and board committee member remuneration (any payment or considerations) in their integrated reports. This will allow for a reasonable comparison of trustee remuneration across the industry

5.3 The CMS and members should also be provided with an indication of how the proposed trustees' and board committee members' fees were determined, as well as the details of the independent advisers who provided advice to the Remuneration Committee on the structuring of trustees' and board committee members' fees.

6. Guidelines for determining Trustee Remuneration

6.1 The following principles should guide the payment of Trustee remuneration:

6.1.1. Trustee remuneration should be based on a professional fee (hourly rate). Professional fees are based on the market related fees charged by professionals in the field of law, actuarial science, medicine and commerce and will be benchmarked and adjusted annually.

6.1.2. The total annual fees payable to trustees and board committee members should be split into an Annual Base Fee (70%) to be paid quarterly in arrears and a Fee per Meeting (30%). The Annual Base Fee is paid quarterly in arrears.

6.1.3. The Annual Base Fees and Fees per Meeting payable to board committee members should differ from those payable to trustees insofar as the duration and frequency of their meetings differ from Trustee Meetings. The number of hours required are different for board committee meetings, taking into consideration their relative strategic importance and time requirements. This recognises the ongoing responsibility of trustees for the efficient control of the Scheme.

6.1.4. Trustees and board committee members hold non-executive status within the Scheme and should therefore in accordance with best practice corporate remuneration governance, not be permitted to be paid consulting fees for consulting services rendered or to participate in any incentive programmes of the Scheme. This ensures that trustees and board committee members are able to act independently of any personal interest when making a fiduciary decision for or on behalf of the Scheme.

7. Deloitte Governance Review of 2018[45]

7.1 In the course of its governance review commissioned by the Scheme in 2018, Deloitte considered various aspects of the Scheme's remuneration practices and concludes in its reports:

7.1.1 The DHMS Board members has a diverse set of skills and knowledge, including legal, finance, medical, human resources and actuarial.

7.1.2 The Board Charter and Scheme Rules includes guiding principles to act as trustee and include principles such as being honest, acting with integrity, and having sound judgement and diligence. The framework and guidelines assist the Board members to be able to act in the best interests of the Scheme.

7.1.3 Trustee remuneration is structured to enable independent fiduciary decision making on behalf of the Scheme, free of personal interest. The remuneration structure is set out in the Scheme's Remuneration Policy and the Remuneration Committee is tasked to recommend remuneration policies to the trustees and Committee members. Independent reviews frequently benchmark the Trustee remuneration and allows DHMS to be aware of Trustee remuneration levels

[45] Discovery Health Medical Scheme (DHMS) Relational Governance Review, 12 September 2018, by Deloitte & Touche Actuarial and Analytical Solutions

outside what can be expected. Trustee Remuneration levels should be considered while taking into account various aspects such as the complexity of a scheme, number of meetings per annum, effort and level of involvement of the trustee members, as well as the management structure and number of board committees of a scheme.

7.1.4 The Remuneration policy does not provide any incentive for a Trustee, receiving remuneration, to act biased.

Appendix C: Trustee elections

1. A formal and transparent selection and nomination process is critical to gain the confidence and trust of all stakeholders, improve the understanding and efficiency of processes in practice and essential to improving Board effectiveness. In particular, important aspects that should be taken into account include:
   1.1 Adequate information disclosures on scheme processes which include the nominations and elections process and the AGM in general,
   1.2 Robust governance processes with regard to nomination and proxy processes are fair and that do not amount to undue influence or conflicts taking into account the Undesirable Business Practise declarations issued by the Council for Medical Schemes; and
   1.3 Robust processes to ensure that elections' processes and results are fair.

2. Communication material

2.1 The timing of information is important and it should be disclosed prior to the AGM, giving the member enough time to review the abilities and suitability of candidates. The Scheme commences its communication processes regarding nominations early in January of the election year and members are afforded a period of 30 days within which to submit the completed Nomination Form.

2.2 The Scheme's communication channels include post, e-mail, advertisements in daily and weekend newspapers and publication of the notice on the web. Apart from sending the maximum information with the Notice of the Meeting, schemes can also use their websites for full information and disclosure. We believe that communication channels that are most effective are in fact e-mail, adverts and the web. With regard to postal material this is not the most inexpensive and trustworthy form of communication and may therefore not meet the intended objective of accessibility. While accessibility is paramount it should be borne in mind that costs of printing and posting material are excessive i.e. in the Schemes experience these amount to at least R1,4 million for a population of approximately 135 000 members. This must be considered and schemes should be allowed to tailor communication process in line with the needs of its demographic/members.

3. Succession planning and scheme environments - the following comments are important in the context of medical schemes:

3.1 One of the primary responsibilities of any board is succession planning. In a traditional governance structure the board, in conjunction with the Nomination Committee, is actively involved in the identification and assessment of candidates. A Nomination Committee (or any other committee identified by a board) is established by a board with a specific mandate to assist with its succession planning process. The Nomination Committee, therefore only acts on a mandate from the board. A Nomination

Committee consists of independent members as well as the Chair of the board and the CEO of an organization.

3.2 In a non-scheme environment the Nomination Committee includes the CEO and the Chair of the Board. The Medical Scheme industry has been instructed in terms of guidelines issued by the Council for Medical Schemes ("CMS"), that this structure is not appropriate. As indicated, owing to these regulatory constraints the Scheme's Nomination Committee consists of three independent members, which is the first fundamental difference to King III which allows the Chief Executive and the Chair of the Board to be members of the Nomination Committee and also allows the Nomination Committee to be chaired by the Chair of the Board. The current Nomination Committee of the Scheme is also the only board committee which currently does not operate under the guidance of the Board of Trustees which could increase operational and governance risk. It is important to note that the Nomination Committee should act on a mandate from the Board of Trustees which the Board needs to clarify with the Nomination Committee.

3.3 The Medical Schemes Act 131 of 1998 and the Rules of the Scheme require that 50% of the trustees should be members of the Scheme and that they should be elected by members at an AGM. In this regard the Rules also set out the qualification and disqualification criteria for trustees. This therefore ensures that there is independence amongst trustees elected and appointed to the Board.

3.4 It must be noted that with regard to re-election of trustees, this is not automatic in that the Board cannot automatically put forward a retiring Board member for re-election – as indicated the Board is not allowed to put forward candidates for election. Within the Scheme environment the retiring Board Member will have to comply with the standard process regarding nominations prior to his or her name being included in the list of candidates standing for election. From a listed company perspective and King IV this right may be exercised by the Board where they agree on the retiring Board members that can stand of re-election whereas in a Scheme environment this right does not reside with the Board.

3.5 The Scheme Rules and the regulatory environment also do not allow for the form of rotation as is provided for in the Companies environment. The Board's continuity is therefore allowed for by giving the Board the discretion to appoint a limited number of trustees to the Board which is not subject to ratification at an AGM and the members of the Scheme have a say in so far as the election of members is concerned.

4. Proposed process and approach

4.1 In order to ensure maximum transparency and independence and within the limitations imposed by the Medical Schemes Act, DHMS believes that the following based on the Schemes experience and its process may serve as valuable guidelines in defining a nominations and elections process for schemes in general:

4.2 Nomination process

4.2.1 In order to ensure transparency and fairness in the process the Nominations and Election processes has been outsourced to an Independent Electoral Body ("IEB"). The Nomination Committee oversees the nominations process for Trustee elections from a governance perspective. The Nomination Committee (as assisted by the IEB) is required to test the eligibility of members standing for election against the criteria as set out in the Scheme Rules and the Medical Schemes Act 131 of 1998, as amended and impliedly also against the guidelines and criteria set out in terms of King IV. Prior to the disqualification of any Nominee, the Nominee will be consulted by the IEB and provided with an opportunity to supply any information as it relates to their disqualification. The Nomination Committee will have the authority to challenge the IEB on the final list of candidates. The Committee will also present the final candidate list to the Board – the Board however has no authority to challenge the final candidate list. This may be a model that can be adopted by scheme's in order to mitigate against risks of collusion.

4.3 Proxy appointments

4.3.1 In order to mitigate the risk of proxy manipulation and to ensure that proxies are not signed under duress a proposed approach is to allow an IEB to design the necessary correspondence, including the content of the proxy appointment form. The IEB will ensure that the proxy appointment forms include relevant built-in security features and unique identification numbers in order to ensure adequate controls and to limit the risk of manipulation of the proxy appointment process.

4.3.2 Other security safeguards include that:

4.3.1.1 The proxy appointment form will only be available on request from the IEB. Each Proxy Form has unique security features.

4.3.1.2 Only Proxy Forms issued to a particular Principal Member can be used by such a Principal Member. No bulk request for proxy forms are addressed.

4.3.1.3 No deletions/corrections on the proxy form will be accepted and will render the form "spoilt". If the Proxy Form is spoilt for some reason, the member shall be obliged to contact the IEB to request a new Proxy Form and the old Proxy Form shall be deemed to be null and void.

4.4 Proxy Vetting Process

4.4.1 The appointment of proxies shall close seven days prior to the AGM and all proxy appointment forms will be vetted within the said seven-day period.

4.5 Trustee Election

4.5.1 The Trustee election takes place at the AGM which is held in June of each year. Prior to the AGM, the IEB will design the layout of the ballot papers, including relevant built-in security features and unique identification numbers to minimise the risks associated with tampering or manipulation of the ballot papers.

4.5.2 During the course of the AGM, the IEB will oversee and authenticate the completion of the Attendance Register by all members in attendance at the meeting and oversee the elections process including the completion of the ballot papers by the members in attendance to ensure that there is no undue influence on members when casting their votes and seal the ballot boxes at the conclusion of the electoral procedure.

4.6 Post-Election Results and Reporting

4.6.1 After the election process on the day, the IEB will:

4.6.1.1 Review all completed ballot papers in order to remove any spoilt ballot papers and count all valid ballot papers in order to compile the election results. The IEB will report on the compliance to the Scheme Rules of the elections as well as any deviation and/or transgression of the process.

4.6.1.2 Make available to the Scheme the names of the successful candidates;

4.6.1.3 Communicate with each candidate whether they were successful or not; and

4.6.1.4 Make available individual results to the candidate upon request.

4.6.2 The IEB shall be obliged to produce a written report to the Board of Trustees in which the processes followed during the election shall be set out in full detail. The report shall also certify that the elections were conducted in compliance with the Scheme Rules.

Appendix D: Restriction on non-healthcare expenditure

1. Currently section 44(8) of the MS Act allows the Registrar to place restrictions on a medical scheme's administration costs:

> *"(8) The Registrar may, on the authority and in accordance with the instructions and directions of the Council, from time to time place any restriction on the administration costs of a medical scheme in respect of any financial year, and may for this purpose prescribe the basis on which such costs shall be calculated."*

2. The proposed changes contained in the MSA Amendment Bill would allow the Registrar to place restrictions on a medical scheme's total non-healthcare expenditure, which means that it would have the power to restrict administration costs as well as all other non-healthcare expenditure. The change is as follows:

> *"(8) The Registrar may from time to time place any restriction on a medical scheme's non - healthcare expenditure in respect of any financial year, either with reference to specified individual components of that expenditure or to aggregate expenditure, and may for that purpose determine the basis on which that expenditure shall be calculated."*

3. If this proposal is accepted the Registrar would be granted the power to control a large number of wide-reaching financial decisions made on a daily basis by the medical schemes. These financial decisions include factors such as a scheme's rentals, the remuneration of staff, and the appointment of external service providers.

4. It would be contrary to principles of good regulation, the Constitution and the Promotion of Administrative Justice Act (PAJA)[46], for a regulator to determine, on behalf of firms and on a discretionary basis, the manner in which a scheme makes financial decisions regarding its expenditure. The amendment would empower the Registrar to make intrusive financial decisions on behalf of the scheme in the case where they are not well placed to do so and there is no identified market failure. This approach is inconsistent with principles of good regulation and the power to do so should be removed.

    4.1. Financial decisions regarding expenditure are commercial decisions that are usually entrusted to managers and executives within the business, and overseen by the board of trustees who have a legal duty to ensure the prudent spending by medical schemes. It is the **t**rustees, who are entrusted to ensure that "the resources of the medical scheme are used in an effective, efficient, economical and transparent manner" (section 56C(b)(i) of the MSAAB). To the extent that the MSAAB provides sufficient governance of the Board of Trustees, any breach of their duties would be adequately provided for.

    4.2. A regulator should not be in a position to displace the business decisions that are best made by the regulated entities themselves. The Registrar is not in a position to

[46] With reference to Section 33 of the Constitution, as well as multiple provisions of PAJA.

determine how a scheme should make financial and commercial decisions and has the potential for negative unintended consequences. The extension of the Registrar's power would inhibit decision making by those in the best position to make those decisions – the trustees themselves. The Registrar should not be permitted to effectively co-manage the scheme unless it assumes co-responsibility for the performance of the scheme, which it does not.

4.3. The amendment would allow the Regulator to intervene in an instance where no market failure has been identified. Medical schemes aim to attract as many members as possible and therefore there is no incentive for schemes to increase costs beyond that which is necessary. Competition within healthcare financing depends on the ability of a scheme to offer value to consumers, which includes containing costs, as well as other dimensions, such as quality of services and innovation. This amendment runs counter to the principle of proportionality – it is highly interventionist in an instance where no market failure has even been identified.

4.4. As with the other discretionary powers described above, this amendment allows for the discretionary treatment of different schemes, which is counter to sound market operation as well as fairness. It is to avoid such discretion that rules of general application are a preferable mode of regulation.

4.5. There are no procedural safeguards in place to ensure that the restrictions in costs as imposed by the Registrar will not have negative effects or that allow for a proper consultative process that would be commensurate with a heavy-handed intervention of this nature.

Appendix E: The role of information for regulators

The proposed healthcare data regime

5. The amendment bills and the HMI propose information databases and registers that are intended to serve various, and sometimes overlapping purposes. These proposals are summarised below.

6. Provisions in the MSAAB. The MSAAB mandates the provision of information in the following ways:

6.1. Section 7(e) of the MS Act is amended to allow the CMS to "collect and disseminate information about any aspect of private healthcare, including information about the prices, utilisation and costs of relevant health services." (words underlined indicate insertions as proposed by the amendment)

6.2. Section 8A (1) of the MSAAB inserts a new section under the Council's power to request information from medical schemes in respect of services rendered by healthcare providers, including number of beneficiary visits, total amount claimed by the healthcare provider (including split by risk and savings). The section recognises that no personal information should be disclosed in relation to the information being provided.

6.3. The new Chapter 3A establishes the "Central Beneficiary Register". The stated purpose of the register is to identify and assess risks within medical schemes and the NHI Fund and to manage the rights and obligations of beneficiaries (as per proposed section 19(A)(2)). The provision further states that the register will be managed by the Registrar who must also determine standards for the operation of the register. The MSAAB does not provide details on the information that would form part of this register, other than to say that it would contain "*information with regard to beneficiaries as may be prescribed: Provided that such information may not provide for the beneficiaries' identity, including his or her names, date of birth, address, identity number, medical scheme membership or health status of the beneficiaries.*" (section 19A (1)).

6.4. Section 32(J) establishes the "Healthcare Providers Register", which the Registrar must establish, maintain and administer. The section provides details on the particulars to be provided for each healthcare provider or establishment, including name, qualifications, registration of the provider, address etc. Providers are required to apply for the enrolment in the register and the Registrar must assign a unique number to the provider. In addition, the Registrar is entitled to request information from a medical scheme on payments made to any healthcare provider in respect of services provided to beneficiaries. Information from the Healthcare Provider Register must be made publicly available to medical schemes, the NHI Fund and other interested parties.

7. **Provisions in the NHIB.** The NHIB provides for the National Information Repository and Data System. Section 34 of the NHIB states that the Fund must contribute to the development and

maintenance of the National Information Repository and Data System as contemplated in section 74 of the National Health Insurance Act.[47] This system is intended to facilitate the implementation and management of the Fund.

7.1. According to section 34(2), the information must be stored by an independent data company to ensure that the data is accurate and equally accessible.

7.2. The provision further provides that in order for a provider to be reimbursed by the Fund, the provider or establishment must submit information as subscribed by the Fund for recording on the Health Payment Registration System. Section 34(3) goes on to list the information required, which includes information such as procedure codes, details of treatments administered, length of stay at a facility, or any other information deemed necessary by the Minister in consultation with the Fund for monitoring and evaluation of national health outcomes.

7.3. Section 34(4) lists how the Fund may use the information for the purposes of planning, monitoring and evaluation, while section 34(5) deals with how information that is confidential should be treated.

8. Under the duties of the Fund (section 5), the NHIB further states that: the Fund must collate utilisation data and implement information management systems to assist in monitoring the quality and standard of healthcare systems (section 5(h); the Fund must monitor the registration, license, or accreditation status of healthcare providers and establishments (section 5(l)), the Fund must liaise and exchange information with the department of health, professional councils and other government departments to achieve the object of the NHIB (section 5(p); and assist in maintaining the national database on the demographic and epidemiological profile of the population (section 5(q)).

9. The DoH's policy on the NHI[48] provides further details on the information gathering function of the NHI:

9.1. To be accredited with the Fund, providers need to meet minimum quality norms and be certified by the Office of Health Standards Compliance (**"OHSC"**), and where relevant by the relevant statutory professional council. To be accredited, providers must submit specific information, which will be used to monitor health outcomes. [49]

9.2. In terms of the NHI Fund's information system, it is proposed that it will be based on an electronic platform, with linkages between the NHI Fund membership database and

[47] This section provides for the development of a comprehensive national health information system that incorporates information by provincial departments, district health councils, municipalities and the private health sector.
[48] DoH National Health Act, 2003. National Health Insurance Policy (dated 28 June 2017) ("NHI Policy")
[49] NHI Policy, p. 54

the accredited and contracted healthcare providers. The information is intended to support various stated purposes:[50]

"a) Monitoring of the extension of coverage in all population sectors;

b) Tracking of health status of the population and production of disease profile data for use in computing capitation allocations;

c) All the financial and management functions;

d) Utilisation of healthcare services by those entitled to NHI services and how this information must be used to support planning and decision making around contracting, purchasing and communication strategies;

e) Quality assurance programmes for healthcare providers;

f) Production of reports for health facilities and health system management; and

g) Research and documentation to support changes as the healthcare needs of the population change."

10. **Recommendations of the HMI.** The HMI provides for the collection of information in a number of ways:

    10.1. The HMI recommends that healthcare practitioners be registered with the Supply-Side Regulator for Health (**"SSRH"**), which will also be the entity responsible for determining how the registration should be maintained. It is also recommended that the SSRH be the only body authorised to issue practice numbers and that these numbers will be used to reimburse the private provider, regardless of whether the payment is from public or private means.[51]

    10.2. In terms of facilities, the HMI recommends that regular monitoring, inspection and reporting will be required for the purpose of licensing facilities and to ensure that a reliable database of supply side services is established. Licensed establishments will have to report to provincial departments of health (**"PDoH"**), who in turn should report annually on the data received. The SSRH is tasked with determining how reporting should occur, including automatic updates to a national data database on facilities that can be accessed by the DoH, PDoHs and the public.[52]

    10.3. The HMI recommends the implementation of a risk adjustment mechanism (**"RAM"**) for a base benefit package offered by all schemes. It is proposed by the HMI that the RAM should be facilitated by the CMS, but should be migrated to a separate, independent body to avoid a conflict of interest with the regulatory role of the CMS. It

[50] NHI Policy, p. 57-58
[51] HMI report, p. 361
[52] HMI report, p. 464

is emphasised that the administrator of the RAM must have the technical capability to perform its role, and must also have legislated structural independence from any entity with a commercial interest (including medical schemes, government, other regulators, etc.). To facilitate the RAM, the HMI states that a database of beneficiaries is required to determine the risk status of each beneficiary. It is recommended that the CMS is tasked with developing and maintain the beneficiary database.[53]

10.4. Recognising the need for better information about the quality of service provided and about outcomes, the HMI recommends that outcomes measurement and reporting should be carried out by an independent statutory professional body that is entirely focused on carrying out this task – the so called Outcomes Measurement and Reporting Organisation (**"OMRO"**). Having a specialist entity is recognised as being important, precisely because of the specialist nature of this task, where "*outcome measures are based on highest professional and scientific standards, designed and fully supported by doctors, and that results can be trusted beyond any doubt – both by the medical practitioner and the patient alike.*" [54] To make OMRO effective, the HMI recommends that it should have legislated legal powers to allow it to collect outcomes data from providers. Finally, the HMI states that the OMRO is consistent with promoting the objectives of the NHI as a strategic purchaser which will require outcomes measures for both public and private providers. [55]

Consideration of information regime according to principles of sound regulation

11. It is accepted and broadly recognised that regulators require access to data and information in order to execute their regulatory mandate and to make sound regulatory decisions, including the determination of rules, monitoring and compliance, and enforcement. It is also widely accepted that information plays a key role in healthcare. What is being proposed through the various initiatives is a regime of health information systems to understand healthcare in South Africa holistically, in an environment where there is very little reporting and publication of information currently. The importance of information in healthcare, particularly with respect to monitoring, is emphasised in the HMI:

> *"Good health information systems are an essential feature of successful quality measurement and reporting systems. Therefore, the development of a well-functioning nationally comparative information system will contribute towards the success of quality measurement and reporting initiatives. It will also help to reduce the fragmentation of information in the healthcare system. However, it will not solve the problem of the lack of information if the*

[53] HMI report, p. 460
[54] HMI report, p. 448
[55] HMI report, p. 450

information is not verified and if it does not compel providers to make available such information."[56]

12. Sound regulation principles apply to the manner in which information is collected and disseminated by regulators and other public bodies. Whilst it is recognised that there is a benefit associated with better healthcare information systems and access to information by regulators, it is also recognised that this benefit comes with a cost – both to the regulators who request the data as well as the regulated entities. The cost comes not only in the form of the administrative burden that this places on the entities involved, but also in terms of the risk associated with the information not being governed properly, particularly with respect to confidential information. Here too, principles of regulation can help inform how information should be managed and also where there might be natural limitations on the information that is requested and compiled.

Information must be linked to a clear purpose and be proportionate

13. There is a question on when regulators might legitimately expect to obtain information and when there might be some limitation on this. In the context of the information gathering role of regulators, regulatory principles which speak to clarity of purpose and proportionality show that the information requested needs to be clearly linked to the mandate of the regulator, must be targeted at a specific purpose, and should not go beyond what is strictly necessary to achieve this purpose. The principle of proportionality would also require that the associated costs must be considered.

14. This principle is illustrated in international examples that show the considerations that go into dealing with confidential information (which requires special care) as well as with respect to investigations and enforcements.

    14.1. The Care Quality Commission[57] applies "a necessity test" when determining how to use their powers to obtain confidential personal information:

    "*To make a decision as to whether it is necessary to obtain, use or disclose confidential personal information, we will consider two factors:*

    Firstly: Whether obtaining, using or disclosing the information is a necessary step for us to perform a particular function – for example, because it would not be possible or practicable, or would require significant and disproportionate extra cost or effort, to perform the function without doing so. We must act in a way that causes minimum interference with the privacy and rights of people who use care services; and this requires us to ask ourselves whether there are other ways of achieving our aim that would minimise such interference.

[56] HMI report, p. 450

[57] The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England

Secondly: Whether it is necessary and in the public interest to perform the function in the particular circumstances. This means that we will consider whether the public interest served by performing the function justifies any potential impact on people's privacy."[58]

14.2. The Australian Securities and Investments Commission (ASIC) publishes a clear protocol on the use of their powers to request information that explicitly acknowledges the cost burden of providing information. Their approach incorporates various elements, such as imposing limits on the scope of the request where possible, transparency and accountability with respect to the decision-making process for data and commitments on protecting confidential information. This approach should not only apply to Inspections as requested by the Registrar, but also to all of the activities that relate to information gathering by the CMS.

[58] The Care Quality Commission, Code of Practice on confidential personal information (December 2010)

Box 1: Extract from the ASIC Guidance on its compulsory information gathering powers

Our approach to the use of our powers

Limiting the burden and intrusion

We recognise that receiving and complying with a notice to produce documents or provide information can be intrusive and burdensome. When we decide to use a power to require production of documents, we will often seek to limit the compliance burden by: where appropriate, consulting with a recipient, before issuing the notice, on the scope of the request in terms of the description of the documents, the amount of time it will take to produce the documents and a convenient location for the production of the documents; only requiring documents that we believe are needed for the surveillance or investigation; providing a reasonable time for complying with the notice; and considering any alternatives to issuing a notice, such as obtaining the documents or information voluntarily.

Accountability and transparency

ASIC is an Australian Government body accountable to the Minister and to Parliament. Use of our powers is subject to parliamentary scrutiny through the Parliamentary Joint Committee on Corporations and Financial Services and the Senate Standing Committee on Economics. From time to time, our powers are also subject to review by parliamentary inquiries.

Many of our decisions are reviewable through the court system. For example, in circumstances where it is alleged that we have used our powers unlawfully or have acted beyond our power, a legal challenge can be commenced through the courts. The Commonwealth Ombudsman can investigate complaints about our processes which may encompass the exercise of our powers.

Within ASIC, decisions to use our compulsory information-gathering powers are subject to an internal scrutiny and approval process. The decision to use our powers is made by senior ASIC staff in the context of the particular surveillance or investigation. A team leader (most likely an executive staff member) is required to approve the specific use of a compulsory information gathering power. An ASIC lawyer performs the final review of a notice exercising a power.

We publish statistics on the use of our most significant compulsory information-gathering powers in our annual report.

Protecting confidentiality

We must take reasonable steps to protect the confidentiality of information we obtain through our compulsory powers. There are, however, circumstances in which we may disclose this information. For example, there may be instances where we are required by a court to produce documents that were provided to us in response to exercise of a compulsory power, or access to a record of an examination may be provided to other government departments or other parties who are litigating a matter to which the examination relates.

Documents or information may be disclosed to third parties on a confidential basis during an investigation if necessary for the investigation.

These requests for access to confidential information are subject to rigorous processes. Our Regulatory Guide 103 *Confidentiality and release of information* (RG 103) explains the practices we will adopt for the disclosure of information we have obtained through the exercise of our compulsory information-gathering powers. In many cases, a person affected by a proposed disclosure will be given a chance to make a submission about whether disclosure should occur.

Source: https://asic.gov.au/about-asic/asic-investigations-and-enforcement/asic-s-compulsory-information-gathering-powers/

15. Applying these principles to the proposed amendments in South Africa, points to the following:

15.1. Section 7(e) is amended to allow the CMS to collect and disseminate information on any aspect of healthcare, while section 8A(1) also provides the Council with the power to request information on a range of elements, such as number of beneficiary visits etc. While it is recognised that the CMS is entitled to request information, it is recommended that in application, the request for information should be guided by the principle of proportionality, must be targeted at achieving a specific, stated purpose and must be linked to the mandate of the CMS. Guidance in terms of how the CMS would approach its request for information in terms of its mandate (such as the ASIC guidelines) would assist in providing regulatory certainty and transparency, particularly as the amendments appear to expand the ability of the CMS to request information on any aspect of private healthcare.

15.2. Clarity of purpose would also shape the nature of the information that is being provided. For instance, the HMI recommends that the CMS maintains a beneficiaries database for the purpose of facilitating the RAM, whilst the beneficiaries register as contemplated in the MSAAB appears to be broader than this, as the stated objective is to identify and assess risk. Clarity on the precise purpose of the proposed beneficiaries register is required, as this should inform the nature of the information that is to be included. Requiring more granularity than is strictly necessary is costly and counter to the principle of proportionality. For instance, if the purpose is for a RAM, this would not necessarily require the maintenance of a database at a beneficiary level, as the example in Ireland demonstrates.

Box 2: Risk equalisation and data collection process in Ireland

Risk Equalisation Scheme (RES) data collection process: Ireland case study

For the purposes of administering the RES scheme, the Health Insurance Authority (HIA) does not keep a central registry but collects data from insurers for two purposes, (i) reporting to the Minister of Health on what the appropriate level of risk equalisation payments and contributions to the fund will be and (ii) for the payment of risk equalisation claims.

According to section 7E of the Health Insurance Act 1994, the HIA is required to provide annually to the Minister of Health, a report which on the basis of returns submitted by insurers, provides conclusions on the appropriate level of the risk equalisation credits and contributions to the fund. The process of collecting the relevant information occurs through the submission of information returns by insurers, and the process can be summarised as:

- **The authority collects half yearly returns from insurers, to contribute to information for the Minister's report.**
- **Information contained in the returns is outlined in the Statutory Instrument Note No. 294 of 2009, and is broken down by cell, which refers groups defined by gender, age category and other related aggregation category. The information return is summarised in Form No.1 of the Statutory Instrument.**
    - **For a relevant quarter of the return period, data on the of insured persons on the first day of the month within each quarter;**
    - **Prescribed benefits for the cell;**
    - **Claims value of by relevant the cell;**
    - **Aggregated information by combining certain cells groups.**

The data required in respect of the risk equalisation scheme claims, is outlined in the forms which are submitted in recognition of a claim. The claims forms, and the relevant data, are submitted annually when the credit is being claimed. In terms of the data, the following is requested:

- **The actual credit claimed under RES, which is broken down as follows:**
    - **The data requirement tables are broadly split by (i) cover (i.e. advanced or non-advanced);**
    - **Then within each table, the breakdown of information is by (i) gender and (ii) age category.**
    - **The data must cover the different periods for which contracts would have been effected with insured members.**
- **Monthly hospital bed utilisation information, which counts the number of nights insured individuals would have spent in a private hospital, for which the credit is claimed.**
    - **The form also requires a totalised amount of the credit claimed, based on the number of nights captured in the table.**
    - **The form does not require the number of nights spent to be broken down by member, age group or gender.**

Sources: Guide to Risk Equalisation Scheme 2017. Available here: https://www.hia.ie/publication/risk-equalisation.; The Health Insurance Authority. (2016). Report to the Minister for Health on an Evaluation and Analysis of Returns for 1 July 2015 to 30 June 2016 including advice on Risk Equalisation Credits, October 2016; The Health Insurance Authority. (2013). Guide to 2013 Risk Equalisation Scheme, May 2013 and Health Insurance Act 1994 (Information Returns) Regulations 2009. S.I. No. 294 of 2009.

15.3. Further clarity is required on the purpose of the proposed Central Beneficiary Register and once this has been properly established, further consideration is required as to

precisely what information is required to achieve the purpose in a cost-effective manner.

Requirement of proper governance of health information systems

Clear framework and structure for the health information regime is required

16. The NHIB, MSAAB and HMI are recommending various information initiatives that all are consistent with the drive to have better information to inform policy and decision-making. The development of the heath information regime requires a coordinated effort to avoid problems with fragmented with inefficient health information systems[59]. This is particularly as the various information initiatives are intended to align with each other and broader policy objectives. For instance:

    16.1. The HMI has stated that the call for the OMRO is consistent with achieving the objectives of the NHI.

    16.2. The MSAAB is explicit that the information from the Healthcare Provider Register must be made publicly available to medical schemes, the NHI Fund and other interested parties.

    16.3. The NHIB also recommends that an independent data company must be appointed to store the data but it is not clear how this would link to the other proposed information initiatives, if at all.

17. The various initiatives should be considered holistically to ensure that they are implemented efficiently and to address data exchange issues such as standards, interoperability and common platforms. A proper system and clarity of roles and purpose would also prevent some of problems that are already apparent with the current proposed information regime.

18. **First, entities are being charged with collecting information, with no clear link to their mandate.** Information requested should be linked to the mandate of the body requesting the information and should serve a clear purpose. For this reason, careful consideration must be given regarding the entity that is ultimately responsible for collecting and maintaining information. It is not evident that the MSAAB has taken this into account with its proposals:

    18.1. The CMS regulates medical schemes, yet the MSAAB proposes that the Registrar establishes the Healthcare Providers Register. It is common cause that regulators should only be engaged in activities that they have been set up to do and it is therefore not at all obvious why the CMS should be collecting information on providers or how this would be linked to executing its mandate. This is also in direct conflict with the

[59] See WHO (2000) Design and implementation of health information systems, where the duplication and waste among parallel health information systems (p.4 is discussed) as well as

Health Professions Council of South Africa ("**HPCSA**"), which regulates the health professions and is responsible for the registration of practitioners. In the context of setting up the OMRO, the HMI too recognises the limitation of the CMS mandate in this regard, which is precisely why the HMI recommended the establishment of a new body with respect to monitoring outcomes:

> *"The MS Act also empowers the CMS to collect and disseminate information about the private healthcare. However, the MS Act does not regulate providers, it is limited to regulating funders. Therefore, these provisions cannot be used to enforce the collection and dissemination of health quality data from providers."*[60]

18.2. Similarly, if the facilitation of the RAM is intended to transition from the CMS to an independent body, as recommended by the HMI, further consideration is required as to which institution should be collecting information for the purpose of facilitating RAM.

19. Second, there is a duplication of information datasets. Effective regulation also considers the costs associated with the information-gathering processes and would seek to reduce the costs, where possible. This is line with principles of proportionality and efficiency. One obvious consideration is the duplication of effort when requesting and collating data. There are already several areas where possible overlaps in the proposed healthcare data regime have been identified:

19.1. With respect to healthcare providers: (i) the MSAAB proposes that the Registrar establish, maintain and administer the Healthcare Providers Register; (ii) the NHIB will require a database of accredited and contracted healthcare providers, a Health Payment Registration System and calls for an independent body to manage its information management systems; (iii) the HMI recommends that healthcare practitioners be registered with the SSRH, with is also tasked with determining how reporting to the national data database on facilities should occur.

19.2. The CMS will maintain a beneficiaries register, while there will also be the NHI Fund membership database (which would include all users and not just those who belong to medical schemes).

20. It is recommended that a coordinated approach is taken to developing the health information regime in South Africa that involves all of the relevant stakeholders. This would be facilitated by bringing all relevant stakeholders together by way of a symposium that is specifically dedicated to determining a framework, where careful consideration is given to the purpose driving the various information initiatives, the appropriate entities responsible for collecting data (including the mandate and technical expertise of the body), standards and protocols, the governance of the systems to maintain the integrity of the data and how this can be

[60] HMI report, p. 441

achieved in a cost-effective manner. This proposal is in line with principles of regulation, where efficiency, effectiveness, clarity of purpose and transparency are all key objectives.

Special care is required with respect to confidential information

21. A particular feature of health information is that it may involve personally identifiable information that is considered highly confidential and sensitive. The MSAAB is explicit that the Central Beneficiaries Register will not include confidential information, whilst confidential information (including user specific information and details related to the health status or treatment) is contemplated as part of the NHI information system, although it is acknowledged that this should not be disclosed to third parties.

22. With regard to confidential personal information, special care is required with how this data is managed, which are all consistent with good regulation principles. This pertains to a number of elements, including:

    22.1. Clear reasons as to why the information is required and ensuring that the information does not go beyond what is strictly required (part of the "necessity test"); and

    22.2. Clear guidelines dealing with confidential information, including identifying lines of responsibility, protocols for disclosure; guidance on anonymisation of data; and audits of governance of confidential data.

23. The special requirement in dealing with confidential health information is recognised elsewhere, where codes of practice are incorporated as part of the health information system regime. For example, in the UK the "Caldicott Principles", provided below, were developed following a review of how patient information was handled across the NHS. It sets out seven principles that organisations should follow to ensure that information that can identify a patient is protected and only used when it is appropriate to do so. These principles have been incorporated into the NHS confidentiality code of practice.

24. In South Africa, the Protection of Personal Information Act (**"POPIA"**), 2013 is the governing legislation for the collection and use of personal information. The purpose of the Act is to ensure constitutional right to privacy by providing guidance on the use of such information. POPIA includes as personal information physical and mental health and wellbeing. The POPIA establishes conditions to regulate processing of information, some of which are closely aligned to the Caldicott principles. For instance, the condition of minimality[61] – which requires that processing of personal information only be undertaken if it is adequate, relevant and not excessive – is similar to Caldicott principle no. 3 "only use the minimum necessary for the purpose". However, the Caldicott principles go beyond this and provide for a clear framework on governance and duty to care for patient related information, recognising the particular sensitivity related to patient information.

[61] Protection of Personal Information Act, 2013, s10.

25. It is recommended that specific care is required for the treatment of confidential personal information. It is proposed that as part of the process to determine a proper information system, a code of practice is developed that includes clear protocols that deal with managing confidential information and an adherence to Caldicott-type principles. This would be consistent with international best practice[62].

[62] See for example, Code of Practice for Health and Social Care in Wales (August 2005); The Care Quality Commission, Code of Practice on confidential personal information (December 2010); American Health Information Management Association Information Governance Principles for Healthcare (2014); Confidentiality: NHS Code of Practice (2003)

Box 3: The Caldicott Principles followed by the NHS

The Caldicott Principles

1. **Everyone must justify the purpose(s) for which patient-identifiable information is used**

Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

2. **Do not use patient-identifiable information unless it is absolutely necessary**

Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. **Only use the minimum necessary for the purpose**

Where use of the patient-identifiable is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

4. **Access to patient-identifiable information should be on a strict "need to know" basis**

Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

5. **Everyone with access to patient-identifiable information should be aware of their responsibilities**

Every use of patient-identifiable information must be lawful. Someone in each organsiation handling patient information should be responsible for ensuring that the organisation complies with the legal requirements.

6. **Everyone with access to patient identifiable information should understand and comply with Data Protection and Security legislation**

Every use of patient-identifiable information must be lawful. Someone in each organsiation handling patient information should be responsible for ensuring that the organisation complies with the legal requirements.

7. **The duty to share information can be as important as the duty to protect patient confidentiality**

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies. Caldicott Guardians are senior staff in the NHS and Social Services appointed to protect patient information. The Caldicott Guardian for Salisbury NHS Foundation Trust is the Medical Director. Further information can be found in the Caldicott Guardian Pages on the Department of Health web site Additional supporting information about data transfer outside the Trust is available within the Policy Processing Personal Identifiable Information by an External Company Outside and within the UK/EEA. Further information is available from the Information Commissioner - Use and Disclosure of Health Data.

Source: https://www.salisbury.nhs.uk/AboutUs/OurPoliciesAndProcudures/Documents/Appendix%20D%20V2.1.pdf

Appendix F: Unilateral restriction of benefits

1. Section 34 of the MS Act prohibits the cession of benefits/rights by medical schemes, and the transfer of benefits by medical scheme members. The MSA Amendment Bill seeks to add a new provision to section 34, which would allow the Registrar to restrict the extent of benefits offered by medical schemes. The Bill proposes the following insertion:

   > *"(3) The registrar may, after consultation with the Minister, restrict the extent of benefits offered by medical schemes, having regards to the benefit and services coverage under the Fund thereby eliminating duplicative costs for the same benefit."* (own emphasis)

2. The inclusion of this provision in the Act is in anticipation of the introduction of the NHI Fund, which is supposed to cover "comprehensive health service benefits". This addition to the MS Act would allow the registrar to unilaterally restrict benefits, without consultation with medical schemes, according to what he/she determines to entail duplicative costs. This is in the instance where: there has been no policy certainty on how medical schemes will co-exist with the Fund, which services will be included in the comprehensive health service benefits package; and how this might change from time to time. This approach is unconstitutional and inconsistent with principles of good regulation and administrative justice and the power to do so should be removed:

   2.1. As with the unilateral ability to amend rules, this amendment allows for the unequal treatment of different schemes, which is counter to sound market operation as well as fairness. It is precisely to avoid such discretion that rules of general application are a preferable mode of regulation.

   2.2. To the extent that this provision is intended to align the role of the medical schemes with that of the NHI Fund, this provision goes beyond what is necessary to achieve this purpose. The purpose can be achieved by ensuring that there is a broad provision that ensures alignment (i.e. a provision that states that medical schemes offerings must be compatible with the requirements of the NHIB) and allowing a scheme to design benefit packages that are consistent with this broad provision. If the Registrar believes that the benefits are not consistent with the NHI, it can then act by pointing it out and requiring action. Proportionality informs a less interventionist approach than that which is being proposed through this provision.

   2.3. Medical schemes compete on benefit option design and pricing, and this is an important element to innovation and competition in healthcare insurance. Benefit design is highly complex and any adjustment to benefits impacts on the value and price of medical insurance. This amendment allows the Registrar to unilaterally adjust benefits, an important parameter of competition, without having the information and expertise to determine the impact that this would have on price, the viability of the package, how this might impact on pricing or the solvency of the scheme. This takes the regulator beyond its area of expertise and again creates the real risk that the decision

is made by an entity (the regulator) which is not responsible for the performance of the scheme, whilst removing this power of the scheme's trustees, who are responsible.

2.4. The MSAAB is proposing an amendment in law that assumes a specific role for medical schemes. However, the policy has not been settled and comments are yet to be made on the NHIB. It would be premature to include any specific provision in the MSAAB which assumes there would be a restriction on medical schemes when this has not yet been established. A coherent framework for the implementation of the NHI and the role of medical schemes would need to be established before any amendment of the MS Act can even be contemplated. Even then, for the reasons already explained, it would be wrong to include an amendment in the proposed form.

Appendix G: Principles of good regulation

1. Regulation refers to any government measure or intervention with the aim of changing individual or group behaviour. The need to regulate health insurance is widely acknowledged. According to the WHO:

   "The case for public intervention in health insurance is based a number of factors, including the rationale for regulating financial institutions in general, market failures specific to health insurance, the public's interest in preserving the health of its citizens and potential policy objectives to address the unequal distribution of income and health risks."[63]

2. Health insurance, like other financial markets, is regulated to manage system risk and instability, by ensuring financial solvency of the insurers, for example. Regulation is also there to protect consumers in a number of ways, such as ensuring that benefits packages provide adequate financial protection for those ensured. Further, market failures inherent to the health insurance market, such as adverse selection and moral hazard, are also addressed through interventions. For example, regulations that mandate open enrolment and community rating are intended to address market failures, as well as achieve policy goals of expanding access to healthcare.

3. Good regulations balance providing adequate protection with limiting adverse effects.[64] From a societal perspective, regulations should achieve objectives efficiently with minimal unintended adverse consequences.

4. The features of good regulation have been described extensively in the economic regulation literature, and recorded in operative principles by international organisations such as the OECD and the World Health Organization, as well as by institutions within individual countries. From these emerge a number of universally accepted principles of good regulation which apply to both economic and non-economic regulation.

   4.1. Regulations should have clarity of purpose, and serve clearly identified policy goals. All regulations passed for a particular purpose should be related to that purpose and targeted at the problem identified.[65] Clarity of purpose also allows for a goals-based approach, which is preferable[66] to overly prescriptive regulations. If clear, unambiguous goals are provided then actors – whether firms, households or public benefit organisations – can determine the best method to achieve these goals.

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[63] World Health Organisation (2005) Regulation Private health insurance to serve the public interest, Discussion Paper Number 3 – 2005, p. 4.
[64] Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 1.
[65] Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 6; OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2; Department for Business Innovation and Skills (UK) (2011) Principles for Economic Regulation, p. 4.
[66] OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2.

4.2. *Regulations should be proportionate, in that they are appropriate to the risk posed.*[67] Costs of regulation should be identified and minimized, and any costs should be justified by the expected benefits of the regulations. When designing regulations it is important to consider all the options (including not regulating) that are available for achieving the particular policy objective.

4.3. *Regulations should be effective and efficient*.[68] Regulations should produce the intended result within the intended time, with the least burden of effort and cost.

4.4. *Regulations need to be consistent, certain and predictable*.[69] To operate efficiently, firms need certainty as to their legal obligations; and to allow for effective planning and investment, the regulatory regime should be predictable over time. If firms are covered by multiple regulatory bodies, these regulations need to be consistent. In addition, regulations should be compatible with government's over-arching policies such as competition, trade and investment policies,[70] and with international norms and agreements.[71]

4.5. *Regulations should be adaptable/flexible*.[72] Regulations should be able to change in response to changing conditions. Regulated firms should be able to use innovative and least cost methods to achieve the purpose of the regulations.

4.6. *The development, implementation and enforcement of regulations should be transparent*.[73] The policy objectives and the need for regulations should be well communicated to all affected parties. The consultative process needs to be fair, with stakeholders given

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[67] See for example: Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 4; New Zealand Treasury (2015) Best Practice Regulation: Principles and Assessments, p. 80; OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2; WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[68] WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[69] Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 5; New Zealand Treasury (2015) Best Practice Regulation: Principles and Assessments, p. 80; OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2; Department for Business Innovation and Skills (UK) (2011) Principles for Economic Regulation, p. 5; WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[70] OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2.
[71] WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[72] New Zealand Treasury (2015) Best Practice Regulation: Principles and Assessments, p. 80; Department for Business Innovation and Skills (UK) (2011) Principles for Economic Regulation, p. 5; WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[73] Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 4; New Zealand Treasury (2015) Best Practice Regulation: Principles and Assessments, p. 80; OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2; WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.

sufficient time and information to respond to proposed regulation. Regulations should be clear and easy to understand, in order for regulated entities to be aware of their obligations and the consequences if they don't comply.

4.7. *Regulations should have a sound legal and empirical basis,*[74] *and should be reviewed regularly.* Regulations should be periodically reviewed for necessity and efficacy. Techniques such as regulatory impact analysis (**"RIA"**) should be used to inform decision making. If not, they should be eliminated or revised. Alternatives to regulation, including self-regulation, are often preferable to heavy regulation.[75]

4.8. *Regulations and regulatory decisions should be impartial.*[76] Regulations are there to achieve a purpose, not to choose sides or advantage the politically connected. Impartiality ensures fairness and avoids conflicts of interest, unfounded bias and undue outside influence.

4.9. *Regulators should be fit for purpose.*[77] The regulator needs to have adequate technical knowledge and the capacity to deal with the issues it is mandated to regulate.

4.10. *Regulators should be accountable*.[78] Regulators should be able to justify decisions and be subject to public scrutiny. Complaints and appeals procedures should be fair and effective.

5. The appropriate limitations on regulators and the role of regulation in general are naturally defined by drawing on these principles of good regulation.

6. **First, regulations are imposed to set rules of general application that constrain the behaviour of entities that would otherwise have an incentive to behave in a way that is counter to the stated objectives.** This is usually linked to some form of market failure that has been identified, or to advance public interest policy concerns. The role of the regulator is then to monitor behaviour and engage in enforcement activities where behaviour does not adhere to the stated rules. For example, the provisions of community rating is general rule of application that is intended to address the incentive of insurers to charge

[74] OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 2; WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[75] Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 2.
[76] WHO (2016) Good regulatory practices: Guidelines for national regulatory authorities for medical products, p. 5.
[77] OECD (2014) The Governance of Regulators, pp. 90-95.
[78] See for example: Better Regulation Task Force (UK) (2003) Principles of Good Regulation, p. 4; New Zealand Treasury (2015) Best Practice Regulation: Principles and Assessments, p. 80; Department for Business Innovation and Skills (UK) (2011) Principles for Economic Regulation, p. 4.

"actuarially fair premiums"[79], which are related to the actual risk the insurer is taking on with respect to each beneficiary. This addresses the broader policy goal of promoting equity through subsidisation between high and low risk individuals.

7. The importance of proper rule design is recognised by the World Health Organization which sets proposals for rule design that conform to the general proposals of good regulation, such as having clarity of purpose and accountability.

[79] World Health Organisation (2005) Regulation Private health insurance to serve the public interest, Discussion Paper Number 3 – 2005, p. 15

Box 4: WHO proposals for setting rules to improve health financing performance

World Health Organization proposals for setting rules to improve health financing performance

1. Rule setting

Where previously absent, the setting and introduction of a new rule or specific rule aspects serves to overcome a regulatory gap. New rules must be adequately formulated and logically linked to the health financing performance indicator(s) in order to create a proper incentive environment.

2. Rule redesign

A rule's purpose, or the detailed health financing aspects it specifies, may need to be reformulated, in order to create or strengthen the logical link(s) with the health financing performance indicator(s). A rule redesign usually results in a revised incentive environment with the aim of making organizations work better towards the health financing performance indicators.

3. Rule alignment

To ensure that a rule is not contradicted by other health financing rules and that it is in line with the country context, norms and capacity levels, the prevailing rules may need to be aligned with each other. The rule under discussion may also need to be adapted, while at the same time maintaining its logical link(s) with the health financing performance indicator(s) via conducive incentives. Alternatively, public awareness raising and information provision may be required to overcome attitudes that are non-conducive to rule compliance and the achievement of the health financing performance indicators.

4. Strengthening rule enforcement

Rule enforcement can be reinforced by specifying enforcement characteristics of a rule, so that the incentives to comply with the rule are more pronounced.

5. Strengthening organizational capacity

Organizational capacity of specific organizational actors can be enhanced through a number of measures of organizational development. These include reinforcing management leadership, staff training, an improved financial basis, infrastructure improvements, or revisiting organizational procedures and structures, through which organizations gain the ability to better implement rules.

6. Improving inter-organizational relationships

Trust-building and conflict management measures, improving the division of labour, transparent communication and collaboration procedures, inter alia, can all help enhance inter-organizational relationships and thus strengthen rule implementation and rule enforcement.

Source: World Health Organization (2010) The role of institutional design and organizational practice for health financing performance and universal coverage, World Health Report Background Paper, 36

8. **Second, regulators are not there to displace the business decisions that are best made by the regulated entities themselves.** Rather, rules are imposed to constrain behaviour of firms generally, who are then able to make business decisions as long as the decisions fall within the stated parameters. Continuing on the example of community rates, this general rule would apply to all medical schemes, who are then able to price the various packages using their own actuarial expertise, as long as the prices adhere to the general rule of community rating. The role of the regulator is to ensure that the premiums charged by

medical schemes adhere to the rule of community rating. The regulator, however, does not determine prices on behalf of each and every regulated entity.

9. This is consistent with the basic understanding of the role of regulation. In the context of economic regulation, *Viscusi et al.*[80] note:

> *"(I)n its role as regulator, a government literally restricts the choices of agents. More formally, regulation has been defined as "a state imposed limitation on the discretion that may be exercised by individuals or organizations which is supported by the threat of sanction"".* (own emphasis)
>
> The Authors go on to state:
>
> *"When an industry is regulated, industry performance in terms of allocative and productive efficiency is codetermined by market forced and administrative processes. Even if it so desired, a government cannot regulate every decision, as it is physically impossible for a government to perfectly monitor firms and consumers. As a result, market forces can be expected to play a significant role regardless of the degree of government intervention."*

10. These authors recognise that the scope of economic regulation is to limit the discretion of regulated firms who are required to deliver within defined constraints, but a regulator cannot substitute all decision-making of firms. There are many good reasons for this:

    10.1. Information asymmetries and the lack of specialist business expertise means that regulators are not well-placed to make business decisions on behalf of firms. The depth of information and expertise that might inform a more interventionist approach by a regulator is not available generally, and certainly not for the private health insurance market where pricing and benefit design is complex and where there are a large number of medical schemes, each with their own set of complexities.

    Dealing with the reform of economic regulation, the National Bureau of Economic Research (**"NBER"**) notes:

    "This may not be surprising: regulating well is very difficult. Regulators typically have far less information on the markets they regulate than do the firms whose activities they oversee, confront limited resources in executing their oversight roles, and may themselves have weak incentives to achieve the outcomes that generate the greatest social welfare."[81] (own emphasis)

    10.2. It is also broadly accepted that regulation will always be imperfect, costly and may result in unintended consequences in the efficient functioning of the market. Recognition of

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[80] Viscusi, W.K., J.M. Vernon and J.E. Harrington Jr. (2001) Economics of Regulation and Antitrust, p. 297

[81] Rose, N. L. (editor) (2014) Learning from the Past: Insights for the Regulation of Economic Activity, NBER, p. 20

the costs of regulation, as well as the potential to have negative consequences, favours an approach that is governed by clear rules that have been properly determined and avoids interventionist and discretionary decision-making on the part of the regulator and its staff. The NBER concludes that:

"Determining the desirability of government intervention therefore requires a careful assessment of the costs of imperfect markets relative to the costs and benefits of imperfect regulation, with full recognition of the inevitable shortcomings in each."[82]

In respect of health insurance in particular, the World Health Organization states:

"Regulating how private companies can price their products is a significant governmental intervention and can have unintended consequences. In health insurance markets pricing policies are particularly difficult to design because there are so many competing objectives: affordability, equity, viability, as well as avoiding adverse selection, risk selection and moral hazard."[83] (own emphasis)

10.3. The principle of proportionality implies that regulations should be appropriate to the market failure it is seeking to address. In other words, it should be no more intrusive than that which is strictly necessary to address the perceived problem and should consider the cost of regulation together with the expected benefits. Proportionality informs a regulatory model where constraints are placed to address specific issues and not a more interventionist approach where regulators make discretionary decisions on behalf of regulated bodies. This approach is also reflected in the promotion of economic regulatory reform, that seeks to promote competition where possible and within the constraints of regulation, rather than adopt a model of state ownership or heavy-handed regulation.[84]

11. **Third, where more interventionist/discretionary regulations are required, this is the exception and appropriate safeguards and processes are needed to ensure sound regulatory outcomes.** It is recognised that there may be some instances where regulators may be tasked with intervening with respect to actual business decisions of regulated entities. For example, this may be with respect to maximum prices, widely considered to be one of the most intrusive forms of regulator intervention. However, such interventions are considered the exception and are linked to specific market failures (for example, utilities that are natural monopolies by virtue economies of scale).

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[82] Rose, N. L. (editor) (2014) Learning from the Past: Insights for the Regulation of Economic Activity, NBER, p. 21

[83] World Health Organisation (2005) Regulation Private health insurance to serve the public interest, Discussion Paper Number 3 – 2005, p. 15

[84] Crampton, P. (2002) Striking the right balance between competition and regulation: the key is learning from our mistakes. APEC-OECD Co-operative Initiative on Regulatory Reform

12. Acknowledging the cost of such interventions, including the potential for negative unintended consequences, such interventionist regulations are usually only imposed in instances where there is a rigorous, consultative process in place that, one, identifies the perceived market failure and, to, ensures that the regulatory intervention is necessary and proportionate to that market failure. This process is required by the principles of good regulation which speak to clarity of purpose, proportionality and accountability.

13. There are good local examples that demonstrate these principles:

    13.1. Before the communications regulator of South Africa, ICASA, can impose any regulation that has implications for competition, including price controls, a clearly set out approach needs to be followed that ensures decisions made are rigorous and that there is scope for consultations with all relevant stakeholders.

    13.2. In respect of market inquiries, the Competition Amendment Bill shows how the principle of proportionality might be applied. Any remedial action taken by the Competition Commission must be reasonable and practicable, the effect of the action must be considered and also whether or not there are less restrictive means to remedy the problem.

14. The details for both of these examples are provided below.

Box 5: ICASA Section 67(4) process

ICASA is required to apply the following process when considering the imposition of procompetitive terms and conditions: define the relevant market; evaluate the effectiveness of competition in the defined market; determine whether any market failure exists, and if so, declare those firms to have significant market power, and impose regulations that include pro-competitive terms and conditions to remedy the identified market failure.

In terms of the legal and procedural process required to prescribe regulations, section 67(4) of the ECA requires the following:

"(4) The Authority must prescribe regulations defining the relevant markets and market segments, as applicable, that pro-competitive conditions may be imposed upon licensees having significant market power where the Authority determines such markets or market segments have ineffective competition. The regulations must, among other things—

(a) define and identify the retail or wholesale markets or market segments in which it intends to impose pro-competitive measures in cases where such markets are found to have ineffective competition;

(b) set out the methodology to be used to determine the effectiveness of competition in such markets or market segments, taking into account subsection (8);

(c) set out the pro-competitive measures the Authority may impose in order to remedy the perceived market failure in the markets or market segments found to have ineffective competition taking into account subsection (7);

(d) declare licensees in the relevant market or market segments, as applicable, that have significant market power, as determined in accordance with subsection (6), and the pro-competitive conditions applicable to each such licensee;

(e) set out a schedule in terms of which the Authority will undertake periodic review of the markets and market segments, taking into account subsection (9) and the determination in respect of the effectiveness of competition and application of pro-competitive measures in those markets; and

(f) provide for monitoring and investigation of anti-competitive behaviour in the relevant market and market segments."

A lengthy consultative process is required, including the publication of draft discussion documents for comments, comments on the draft discussion document, public hearings, the publication of draft findings; comments on the publication of draft findings and then the publication of the final findings document.

Source: Electronic Communications Act of 2005

Box 6: Proposed process for remedial actions following a market inquiry

The Competition Commission has proposed in its Competition Amendment Bill, the introduction of a provision which deals with the duty to remedy an adverse effect on competition in a market, following a market inquiry. The Competition Commission is contemplating remedial action which seeks to balance the extent of the adverse effect on competition against the extent of the remedial action, which also creates a provision which should consider the availability of a less restrictive remedy. The proposed insertion in section 43D of the Competition Act reads:

"(1) Subject to the provisions of any law, the Competition Commission may, in relation to each adverse effect on competition, take action to remedy, mitigate or prevent the adverse effect on competition.

(2) The action taken in terms of subsection (1) may include a recommendation by the Competition Commission to the Competition Tribunal in terms of section 60(2)(c).

(3) The decision of the Competition Commission in terms of subsection (1) must be consistent with the decisions of its report unless there has been a material change in circumstances since the preparation of the report or the Competition Commission has a justifiable reason for deciding differently.

(4) Any action in terms of subsection (1) must be reasonable and practicable, taking into account relevant factors, including—

(a) the nature and extent of the adverse effect on competition;

(b) the nature and extent of the remedial action;

(c) the relation between the adverse effect on competition and the remedial action;

(d) the likely effect of the remedial action on competition in the market that is the subject of the market inquiry and any related markets;

(e) the availability of less restrictive means to remedy, mitigate or prevent the adverse effect on competition; and

(f) any other relevant factor arising from any information obtained by the Competition Commission during the market inquiry."

Source: Competition Amendment Bill, 2018.

15. To ensure that any regulations imposed are effective and proportionate, they should be reviewed for necessity and efficacy. Robust regulatory impact assessments comparing the regulations against the likely counterfactual in terms of costs and benefits should be used to inform decision-making and to assure regulatory quality. This is regarded as a guiding principle by the OECD for ensuring regulatory quality as described below.

Box 7: Extract from OECD Guiding Principles for Regulatory Quality and Design

> **Assess impacts and review regulations systematically to ensure that they meet their intended objectives efficiently and effectively in a changing and complex economic and social environment.**
>
> Review regulations (economic, social, and administrative) against the principles of good regulation and from the point of view of those affected rather than of the regulator; update regulations through automatic review procedures such as sun-setting.
>
> Consider alternatives to regulation where appropriate and possible, including self-regulation, that give greater scope to citizens and firms; when analysing such alternatives, consideration must take account of their costs, benefits, distributional effects, impact on competition and market openness, and administrative requirements.
>
> Use performance-based assessments of regulatory tools and institutions, to assess how effective they are in contributing to good regulation and economic performance, and to assess their cost-effectiveness.
>
> Target reviews of regulations where change will yield the highest and most visible benefits, particularly regulations restricting competition and market openness, and affecting enterprises, including SMEs.
>
> Review proposals for new regulations, as well as existing regulations, with reference to regulatory quality, competition and market openness; ensure compliance with quality standards when drafting or reviewing regulations preferably overseen by a body created for that purpose.
>
> Integrate regulatory impact analysis into the development, review, and revision of significant regulations, and use RIA to assess impacts on market openness and competition objectives; support RIA with training programmes, and with ex post evaluation to monitor quality and compliance; include risk assessment and risk management options in RIAs. Ensure that RIA plays a key role in improving the quality of regulation, and is conducted in a timely, clear and transparent manner.
>
> Minimize the aggregate regulatory burden on those affected as an explicit objective to lessen administrative costs for citizens and businesses and as part of a policy stimulating economic efficiency. Measure the aggregate burdens while also taking account of the benefits of regulation.

Source: OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance, p. 4

16. An impact assessment is standard practice by regulators in other jurisdictions and sectors prior to the imposition of any form of regulation. For example, both the communications regulator in the UK and the energy regulator in South Africa, NERSA, recognise the importance of RIAs, which reflects principles of good regulation such as proportionality, transparency and efficiency.

Box 8: Extract from Better Policy Making, Ofcom's approach to Impact Assessment

Ofcom's approach to Impact Assessment

The decisions which Ofcom makes can impose significant costs on our stakeholders and it is important for us to think very carefully before adding to the burden of regulation. One of our key regulatory principles is that we have a bias against intervention. This means that a high hurdle must be overcome before we regulate. If intervention is justified, we aim to choose the least intrusive means of achieving our objectives, recognising the potential for regulation to reduce competition.

Impact Assessments are also useful tools for reviewing existing regulation. They provide a framework for weighing up the costs and benefits of removing regulation, as well as analysing other options. In identifying options, we will aim to consider a wide range of options, including not regulating. Where appropriate, we will explore more risk-based, targeted approaches to regulation and will consider whether there are alternatives to formal regulation, such as co-regulation.

In developing policy proposals, our aim will be to think widely about the possible impacts, taking account of the whole value chain and knock-on effects across the communications sector. By doing so, we will seek to minimise any unintended consequences. To be effective, the process of doing an Impact Assessment should begin right at the start of a project, with the Impact Assessment being developed from then onwards. An Impact Assessment should therefore be a core part of the policymaking process, not a bureaucratic add-on.

Source: Ofcom (2005) Ofcom's approach to Impact Assessment, p. 3

Box 9: Extract on NERSA's approach to RIAs

NERSA's approach to RIAs

In regulating the Petroleum Pipelines industry, the National Energy Regulator of South Africa (NERSA) adheres to the regulatory principles of transparency, neutrality, consistency and predictability, independence, accountability, integrity and efficiency. It is therefore necessary to constantly assess the important decisions taken by NERSA in order to understand the regulatory impact on the wide range of stakeholders in the South African economy and society.

NERSA is in the process of developing an appropriate tariff methodology for the approval of tariffs for petroleum storage and petroleum loading facilities. In developing this methodology, it is necessary for NERSA to perform the Regulatory Impact Analysis (RIA) of the asset valuation methodologies available for determining tariffs. Stakeholders are also encouraged to comment on other elements of the methodology such as depreciation, Weighted Average Cost of Capital (WACC), taxation, clawback, operating cost etc.

Of utmost importance in the development of the RIA is stakeholder consultation to determine the concerns and/or the impact of the policies, methodologies and other instruments used by NERSA, on key stakeholder groups.

Source: NERSA Survey for the Regulatory Impact Assessment of Tariff Methodologies - Petroleum Pipelines Industry

Appendix H: Ability of the Registrar to change medical scheme rules

1. Section 31 of the MS Act deals with the amendment of medical scheme rules. Rules of a medical scheme form the cornerstone of how a scheme is managed. It contains inter alia a scheme's benefits and contributions, exclusions and limitations, how brokers are compensated, descriptions of the various benefit options, and details on healthcare services and medication covered under the various options.

2. As the MS Act stands, section 31(3) states that the Registrar must approve or reject a change (any amendment, rescission or addition) in rules, and that approval requires that the change is not unfair to members and is not inconsistent with the MS Act. Section 31(4) confers powers on the Registrar to order a medical scheme to amend its rules in response to that medical scheme's request to change its rules, or to apply any rule in a specified manner where that rule is being applied inconsistently with the Act. Section 44 deals with inspections and reports, and 44(11) states that the Registrar may amend a medical scheme's rules if it fails to amend them as directed by the Registrar in response to an issue of financial soundness.

3. Section 12 of the Bill seeks to amend section 31 of the MS Act by way of substituting the powers of the Registrar in section 31(4) with the following: "*The Registrar may, in writing, direct a medical scheme to amend its rules within a period of 30 days after the date of such a directive, in the manner required by the Registrar in that directive,*" and by way of adding section 31(5) to the Act:

   "(5) (a) Where a medical scheme fails to amend its rules in compliance with the directive issued under subsection (4), the Registrar may proceed to effect the necessary amendment to those rules.

   (b) Any amendment of the rules of a medical scheme by the Registrar under paragraph (a) is for all purposes in law deemed to have been effected by the medical scheme itself. "

4. The interpretation of the proposed amendments to section 31(4) of the MS Act, read together with the addition of 31(5), will allow the Registrar to make changes directly to the rules of a medical scheme. This is a shift from the existing position where the Registrar would be required to approve requested amendments and if he/she did not approve, would be required to provide reasons for the rejection. This change empowers the Registrar to change unilaterally fundamental aspects of how an individual scheme is managed on a day-to-day basis.

5. It is understood that the amendment will effectively allow the Registrar to unilaterally and on a discretionary basis, amend the rules of a scheme. This is inconsistent with the Constitution, principles of good regulation and administrative justice and the power to do so should be removed:

   5.1. As a medical scheme is governed through a system of rules, this enables the regulator to intervene on fundamental aspects of how an individual scheme is managed on a day-

to-day basis. This is in the instance where the regulator is not well-placed to assess the impact that a change will have on the business of a scheme and where decisions may have substantial unintended consequences. This takes the regulator beyond its realm of competence and creates a risk that the decision on rules is made by the Registrar (which is not responsible for the solvency of the scheme), whilst removing this power from the entity that is (the trustees of the scheme).

5.2. This amendment allows for the unequal treatment of different schemes. This is counter to sound market operation as well as fairness. It is precisely to avoid such discretion and the potential for lobbying and inappropriate conduct created by it that rules of general application are a vastly preferable mode of regulation.

5.3. There are no procedural safeguards in place to ensure that the change in rules by the Registrar will not have negative effects or that allows for a proper consultative process that would be commensurate with an intervention of this nature.

5.4. If the purpose is to ensure that the rules of a medical scheme are consistent with the rules put in place on schemes more generally, such an amendment is not necessary. The current provisions of the MS Act are sufficient to ensure that a medical scheme's rules are consistent with the rules and regulations of the MS Act. If the Registrar believes an entity has infringed such a rule, it is able to act by pointing out the infringement and requiring action. Proportionality informs a less interventionist approach than that which is being proposed through this provision.

Appendix I: Price and cost determination for healthcare services

1. There is an additional question as to how prices should in fact be determined with respect to the National Health Insurance Fund and whether or not this should fall under the ambit of a ministerial committee or a more specialised institution that is independent.

2. According to the OECD, price determination is recognised as a common feature of public healthcare systems, where some form of price or cost is determined for the provision of medical services.[85] It is common cause that determining costs and prices for healthcare services is inherently complex:

    2.1. There are various methods which can be employed in the design of provider payment systems and these have to be properly considered. The methods depend on[86]: (i) whether payments are made before or after a service is delivered (prospectively or retrospectively), and (ii) as to whether the payment system is on a variable or fixed payment basis. In terms of the payment form, there are a variety of options: (i) capitation method; (ii) case-based payments (e.g. by diagnosis-related groups); (iii) fee-for-service; (iv) global budgets; (v) line-item budgets; and (vi) per diem for daily patient admissions.[87] As demonstrated by the quote below, the task of establishing which system to adopt requires time and technical expertise.

    "When purchasers have to develop a payment system, they rarely have enough time or technical resources to design an optimal one. They may lack technical capacity and sound baseline information on costs and volumes of needed care. Their decisions on incentives must revert to options based on readily available information, technical capacity, and time available to design, build, operate, and then monitor the payment system."[88]

    2.2. It is acknowledged that the price that purchasers of healthcare products and services pay should be reflective of the costs involved in the provision of services.[89] However, determining these costs is a complex exercise, which needs to minimise the incentives of over- or underutilisation. A method of estimating costs has to be determined,

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[85] Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing, p. 14.
[86] See Waters, H. and Hussey, P. (2004). Pricing Health Services For Purchasers: A Review of Methods and Experiences. HNP Discussion Paper, p.3.
[87] Joint Learning Network for Universal Health Coverage. (2015). Assessing health provider payment systems: a practical
guide for countries working toward universal health coverage. Washington, DC: Results for Development
Institute, p.4.
[88] Langenbrunner, J. C., O'Duagherty, S., & Cashin, C. S. (Eds.). (2009). Designing and Implementing Health Care Provider Payment Systems: " How-to" Manuals. The World Bank, p.17.
[89] Waters, H. and Hussey, P. (2004). Pricing Health Services For Purchasers: A Review of Methods and Experiences. HNP Discussion Paper, p. 8.

including tracking and allocation of costs across different cost centres, and understanding how to adjust costs to reflect externalities.[90]

2.3. The degree of complexity is reinforced by the large number of procedure codes for which a price needs to be determined, as was reflected in the determination of the National Heath Reference Pricing List.

2.4. The level of complexity also depends on the pricing regime that is applied. The Policy document on National Health Insurance recognises the need to apply capitation for case-based payment systems as in the case of diagnosis-related groups (DRGs) for in-hospital services.[91] DRGs are designed to adjust for patient complexities and the OECD recognises the intensity of data requirements and the complex array of variables which are required for DRGs.[92] Not only are the DRG cases capturing listed procedures, however, for the purposes of cost determination, they incorporate services such as admission, preparation and maintenance of medical equipment and facilities.

3. In addition to requiring an entity that is capable of dealing with the complexity of healthcare, there is also a further question of whether or not this entity should fall under the Department of Health or should sit elsewhere. The World Health Organization documents that although some countries have elected a purchasing department within the Ministry of Health, others have assigned the purchaser role to agencies independent of the ministry, to create some level of autonomy in contracting for and allocating funds to healthcare goods and services.[93]

4. According to the OECD, several countries have set up technical independent agencies to focus on the technical task of determining costs as being distinct from the more political exercise of negotiating how much to pay for medical services.[94]

> *"A recent trend across OECD countries has been the establishment of independent agencies to develop and maintain DRG schedules. These agencies, now present in France, Germany, Netherlands and Australia seek to locate the task of setting the DRG schedule outside the direct operational responsibility of government ministries, in part motivated by an attempt to 'de-politicise' this task (..). The establishment of national independent agencies can work to ensure comparability and a harmonisation of clinical classification across hospitals, and in some countries, between public and private hospitals.*"[95]

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[90] *Ibid,* p.11.
[91] Depart of Health. (2017). National Health Insurance for South Africa. Towards Universal Health Coverage, White Paper., pp. 2 and 19.
[92] Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing, p. 25.
[93] *Ibid,* p.4.
[94] Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing, p. 17.
[95] Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing, p.29.

5. By way of example, in Australia, the Independent Hospital Pricing Authority[96] is set up as an independent government agency which reports to the Minister of Health.[97] The authority is tasked with determining the National Efficient Price and the National Efficient Cost for healthcare services provided by public hospitals, to inform Activity Based Funding[98] (**"ABF"**) by the state. The authority determines a pricing framework for Australian Public Hospital Services. IHPA's ABF branch is composed of 6 specialised teams for carrying out its duties, namely, Policy Development; Data Acquisition; Classification and Coding Standards; Mental Healthcare; Hospital Costing; and Pricing.

6. It should be appreciated that consideration of the design process for price and cost determination is important: it informs costs for budgetary contributions towards healthcare[99]; and balances utilisation incentives of the provider. In addition, prices set in the public sector act also as a reference point for private healthcare. According to the OECD, this is the case as often private providers interact with the public sector to provide individuals with services entitled to them as part of mandatory public healthcare. As such, for private providers, any basis for negotiation of payment with private insurers will be anchored on the public healthcare service rates.

   "[P]ublic health insurers are the largest source of financing for hospital services and what public health insurers' pay will often form the floor for that sought by private hospitals from private health insurers."[100]

7. It is recommended that proper consideration is given as to how prices will be determined for the Fund. In line with good principles of regulation, the body tasked with the determination of prices should be impartial (to ensure fairness and in order to avoid conflicts of interest, unfounded bias or undue outside influence) and must have specialist technical knowledge and the capacity to deal with the issues. Given the complexity involved in determining prices, there is a good case to consider establishing an independent institution that is mandated with the technical task of determining costs and recommending prices. This approach also consistent with the recommendations of the HMI in setting up a supply-side regulator for healthcare, where it is recommended that this body is independent and has oversight over the determination of tariffs, while it is also proposed that an independent arbitrator will determine final tariffs in instances where agreement cannot be reached.

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[96] See IHPA website. Available here: https://www.ihpa.gov.au/.
[97] See page on IHPA website. Available here: https://www.ihpa.gov.au/who-we-are/our-people
[98] Activity Based Funding
[99] Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing, p. 8.
[100] Kumar, A. et al. (2014), "Pricing and competition in Specialist Medical Services: An Overview for South Africa", OECD Health Working Papers, No. 70, OECD Publishing, p.14.