



HEALTH MARKET INQUIRY



competition commission
south africa

competition regulation for a growing and inclusive economy



Executive Summary

FEATURES OF THE SOUTH AFRICAN PRIVATE HEALTHCARE SECTOR

1. The South African private healthcare sector comprises a complex set of interrelated stakeholders that interact in markets that are not transparent and so not easily understood. This report highlights key features that describe how the private healthcare sector operates. In some instances we identify features of the private healthcare sector that, alone or in combination, prevent, restrict or distort competition. Later in the report, we also provide recommendations to remedy these adverse effects on competition. Understanding our proposed package of remedies requires an appreciation of the complexity of the market.
2. The South African private healthcare sector is part of a two-tier national health system. The public health sector does not pose a significant competitive constraint to the private sector for patients or for service providers. The public sector is not a big purchaser of services from the private sector and so, unlike other countries, public sector tariffs do not influence what is charged in the private sector.
3. Overall, the market is characterised by high and rising costs of healthcare and medical scheme cover, highly concentrated funders' and facilities' markets, disempowered and uninformed consumers, a general absence of value-based purchasing, ineffective constraints on rising volumes of care, practitioners that are subject to little regulation and failures of accountability at many levels.
4. The market displays consistently rising medical scheme premiums accompanied by increasing out of pocket payments for the insured, almost stagnant growth in covered lives and a progressively decreasing range and depth of services covered by medical scheme options, which there are numerous, all of which are difficult to understand fully.
5. It is generally believed that the private healthcare sector provides better quality care when compared to the public sector. However, this is difficult to assess objectively as the SA private market does not have any standardised means of measuring and comparing quality of healthcare services or outcomes. There is no measure of cost-effectiveness in the private healthcare sector.
6. The initiation of this inquiry was motivated by high and increasing expenditure and costs of private healthcare in South Africa. Unaffordability of private health insurance is compounded by variable access to healthcare services based on geographic location and availability of health facilities and specialists, who are concentrated in urban areas.



7. The evolution of the market to its current form is a consequence of a changing regulation environment which saw periods of deregulation in the late 1980s and then partial re-regulation which has led to the status quo. The end result is that facilities are not regulated beyond the requirement of a licence to operate and practitioners are licensed to practise by the HPCSA but little more. The funder (demand) side of the market is characterised by significantly more regulation including open enrolment, community rating and a prohibition of risk rating. However, the funders' regulatory regime is incomplete
8. The overall incomplete regulatory regime can largely be attributed to a failure in implementation on the part of regulators and inadequate stewardship by the Department of Health over the years. Many of the recommendations we have considered are already provided for in current legislation but have not been implemented.

Practitioners

9. Practitioners are usually the point of entry into the health care market. Due to their superior health care knowledge, they act as agents for consumers. Practitioners are able to influence healthcare expenditure in two ways: through their own activities, such as diagnoses and treatment, and through the services and treatments they recommend, which include referral for further investigation, treatment, and hospitalization. Overall, medical practitioners drive much of the health care expenditure in the sector.
10. Doctors organise themselves in a number of ways. General practitioners frequently form Independent Practice Associations (IPAs) that in general aim to promote members' inclusion in preferred provider networks. The GP networks often include some form of quality assessment but none of this information is made public. While these quality assessments are supposedly based on peer review methods, we found no evidence of consequences for practitioners who do not meet satisfactory levels of quality, however it is measured.
11. Specialists form specialist associations or societies which aim to ensure that specialists are well remunerated in addition to other activities. There are elements of the way that specialists' associations cooperate that is anticompetitive despite earlier competition rulings that doctors may not negotiate collectively. This is more evident among some specialist groupings than others. We found that specialists sometimes operate collectively to resist joining preferred provider networks and to introduce or adapt codes that push up prices without commensurate improvement in quality of care or value.
12. Another characteristic of the South African health market is the preservation of solo practices with little or no integrated care. There is a failure in most instances to explore multidisciplinary models of care. Fee-for-service billing is the standard with little appetite to move away from this model.
13. Fee-for-Service (FFS) models of remuneration are known to stimulate oversupply which results in wasteful expenditure and incentivises practitioners to provide more services than needed. This incentive is intensified by the current unregulated pricing environment.
14. The ethical rules of the Health Professions Council of South Africa (HPCSA) are cited as the reason for lack of innovation in models of care and development of alternative reimbursement models. It is our view that the HPCSA is not sensitive to the benefits of competition in creating incentives for affordable and quality care.
15. Where new models of care have been attempted, funders have been slow to embrace such models.
16. A weakness of the private sector is the lack of accountability on the part of practitioners. Globally accepted teaching and continuing professional development interventions such as case review, peer review, and morbidity and mortality meetings are absent in the private sector. Private practitioners are not obliged to subject themselves to review by their peers as a means of quality assurance,

nor do they report any outcomes. Public sector practitioners who work in the private sector in terms of the policy on “Remunerative Work Outside Public Service (RWOPS)” abandon these tried and tested traditions that are present in the public sector, when they do private work. Academics have also shown little leadership in driving evidence-based best practice in the private sector.

17. Intrinsic and extrinsic incentives in the market have promoted over-servicing by medical practitioners which include increased admissions to hospitals, increased length of stay, higher levels of care, greater intensity of care or use of more expensive modalities of care than can be explained by the disease burden of the population.
18. We have found evidence of supply induced demand. Absolute age-adjusted hospital admission rates increased significantly from 2010-2014 (the period for which we had data) and were higher than all but two of 17 OECD countries compared against. Specific discretionary surgical procedures were compared against comparable countries and utilisation rates in the private sector were higher than the average for 6 of the seven procedures studied, and the highest of all countries for 4 out of seven.
19. Age-standardised Intensive Care Unit (ICU) admission rates in South Africa were higher than all the eight countries with comparable published data. If the ICU admission rate per person were reduced to half of its current level (i.e. to between levels found in Belgium and the US); and half of the costs associated with these avoided ICU admissions were reinvested in better ward-based care, approximately R2.7 billion would still be saved annually – just over 2% of private healthcare spending overall for the period studied.
20. After adjusting for factors likely to influence admissions we found that, for nine out of

eleven specialties examined, there was a significant positive correlation between risk of admission and number of doctors or hospital beds in that geography. The same relationship was shown for ICU admission and numbers of ICU beds.

21. Stakeholders confirmed that facility groups compete to attract practitioners, specialists in particular. There is little need for explicit or formal collusive agreements; there is alignment of interests between facility and practitioner where both stand to benefit from higher treatment volumes and intensity. The uninformed patient assumes that these arrangements are always to his/her advantage and is not concerned with the longer term financial impact on medical scheme cover.
22. There are 2.12 medical practitioners per 1000 population in the private sector (0.92 GPs per 1000 and 0.83 specialists per 1000) compared to 0.3 medical practitioners per 1000 population in the public sector¹. As there are no accepted norms about how many medical specialists are required, it is only possible to draw conclusions about over or under supply of medical practitioners once their behaviour in the market is revealed. The evidence of supply induced demand we have presented implies that there is time for doctors to over-service. This is particularly the case for specialists. This indicates that there is not an absolute undersupply of specialists but points rather to an inefficient use of their time.

Funders

23. While significant marketing takes place in the schemes market, consumers are not able to compare what schemes offer. With approximately 270 plans on offer, consumers cannot compare these nor can they choose scheme and plan options on the basis of value-for-money.

1. For the private sector the denominator is the insured population and for the for public sector is the non-insured population

24. We disagree with administrators of open medical schemes and self-administered medical schemes' that this complexity primarily reflects innovation. Rather, the deliberate manner in which these offerings are bundled, packaged and priced allows medical schemes to weaken, even avoid, outright price competition.
25. Multiple options are also a result of the incomplete regulatory environment and have influenced the form of competition in the funders market. To mitigate for the effects of the absence of a risk adjustment mechanism, funders have adapted in a range of ways, including: preferentially attracting the young and healthy to join their schemes; and effectively enforcing risk rating through a proliferation of options that require a joiner to self-select into a scheme option that they can afford. Thus, they compete at a cosmetic level predominantly on choice of products available to consumers rather than on value for money.
26. Other strategies funders employ to make products appear more affordable include the consistent reduction in the range of benefits covered over time. There has also been an "actuarial solution" to the high cost of care in the form of the "more affordable hospital plans". These products have had the predictable consequence of more care being shifted to hospitals, ultimately raising costs and eventually contribution levels, ironically making the cost of cover less affordable. Hospital plans create the impression that all treatment must occur in hospital. However, these plans cover, by law, all PMBs and the stipulated chronic conditions, many of which can be managed outside of hospital.
27. All these factors leave consumers confused and disempowered, compounding their inability to use choice as a pressure on schemes.
28. Schemes demand almost no accountability from administrators to ensure that administrators manage supply-induced demand and procure services based on value from the supply-side of the market.

We expect medical schemes to be aware of supply-induced demand and moral hazard and to ensure that their administrators actively manage these to protect scheme members' health and financial interests. An ability to effectively manage these (and clearly demonstrate it) should be a competitive advantage for any administrator. Regulatory constraints notwithstanding, a widespread inability to manage moral hazard and supply-induced demand would suggest a lack of effective competition in the market for administration.

29. Our competitive analysis indicates that this absence of competitive pressure is primarily due to disempowered and uninformed consumers. There is no method for consumers to assess the value of the services that schemes procure on their behalf. Without understanding this, consumers cannot hold trustees and Principal Officers to account. Consequently, trustees and Principal Officers experience no pressure to hold administrators and managed care organisations to account.
30. Schemes and administrators 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. Ready examples include:
 - 30.1. Inadequate proactive management of PMB payments likely to reduce scheme exposure to mandatory PMB costs;
 - 30.2. Instances of payment from savings accounts instead of risk pools;
 - 30.3. Acknowledgment by funders that databases of their members' physical addresses are not as accurate as they should be, raising questions about the accuracy and value of their DSP networks;
 - 30.4. Alternative Reimbursement Models (ARMs) being driven by hospital groups who also often determine

carve outs and thresholds at which ARM charges revert to FFS; and

- 30.5. Absence of evidence that supply induced demand is being effectively monitored and managed.
31. The tentative and ineffective use of ARMs, including the large carve outs that are a feature of many of the existing arrangements between funders and hospitals, suggests that purchasers either do not have or do not exercise strategic purchasing power. The concentration of the hospital market (discussed below) may account for this.
32. Slightly more effective network arrangements are beginning to appear. A GEMS Efficiency Discount Option resulted in a number of efficiency savings² and consumer benefits.³
33. A common refrain is that some schemes are deemed to be “too large to change administrators”. Bonitas claims it is too large to switch from Medscheme, but it is actually not much larger than Polmed which has recently changed administrators. DHMS is also considered to be too big to move. In addition, DHMS also indicates it is unlikely to change administrators due to the vested outsourcing model it has with DH which, according to 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. Rather, trustees should be looking for value for scheme members.

Funder Concentration

34. Although there are 22 open medical schemes, this market is concentrated as two medical schemes constitute approximately 70% of total open scheme market as measured by

number of beneficiaries. There is, however, one dominant open medical scheme, Discovery Health Medical Scheme (DHMS), that comprises 55% of the open scheme market, and it continues to grow organically and through a series of amalgamations with smaller restricted schemes. The Government Employees Medical Scheme (GEMS) is the largest restricted scheme and is second only to DHMS as measured by number of beneficiaries.

35. There are 16 medical scheme administrators in the market. Discovery Health and Medscheme account for 76% of the market based on gross contribution income (GCI), which makes the administrator market highly concentrated as well.
36. We have observed no meaningful entry in the funders market over at least a decade.
37. There is some evidence of competition between funders, particularly amongst administrators. Examples include previous litigation brought by Afrocentric in relation to Discovery Health’s method of tariff negotiation on behalf of all its schemes with service providers, which Afrocentric have claimed is anticompetitive. The recent switching of large medical schemes, Bankmed and Polmed, from Metropolitan Health to Discovery Health and Medscheme respectively, has also been cited as an example. However, competition could be much more improved if transparency, accountability, supplier-induced oversupply of care and value-driven healthcare were priorities of scheme trustees and administrators.
38. We have not noted any existing players seriously challenging the dominant players. We have also not seen any innovative (disruptive) competition.

2. A 10% reduction in doctor hopping, a 22% reduction in specialist consultations, and a 16% reduction in hospitalisations is reported. Combined, these stipulations resulted in 12% lower costs despite the option having a worse risk profile.

3. A 10% discount on monthly contributions, for the same level of benefits is reported to have been passed on to member of this option.



39. The corporate identities of some of the administrators, e.g. Discovery Health and MMI administrators (Momentum and Metropolitan), are linked to those of related corporate groups with broad interests in insurance, asset management, property and other sectors. Of interest to the HMI is that some of the broker arrangements within these groups have the effect of blurring the lines between medical scheme and other insurance products and services.
40. We have previously referred to common ownership arrangements between DH, MMI and Mediclinic. Though MMI and DH have provided some examples of competition between them, we believe that common ownership between two of the largest administrators and of the large hospital groups might influence strategic direction and can have a chilling effect on competition over the long term. For example, we wonder whether large administrators would consider investing in or owning their own facilities absent the financial links between them.

Funder Profitability

41. Sustained levels of profitability have been found across the funder market. Discovery Health has, over a sustained period of time, earned profits that are a multiple of those of its main competitors, with no sign of effective challenge from incumbent or new firms.
42. We acknowledge that much of DH's success is partly due to a highly competent management team, but we do not think this alone explains the significant gap in profitability when compared to its direct competitors. Higher than necessary service fees given economies of scale, a "locked-in" DHMS that does not source services from any other industry stakeholder, risk selection and broker management contribute to its profitability.

43. Under normal competitive conditions, DH's profitability would attract new competitors and stimulate competition from incumbents. There is no sign of this. On the contrary, we see DH growing and becoming more successful over time. This is an indication of market failure and there are no signals that the market will self-correct.
44. The top three administrators (Discovery Health, Medscheme and MMI) should have countervailing power to the three big hospital groups. Our observation is that Discovery Health does apply this power better than its two large competitors, as shown by its ability to negotiate consistently better tariffs. GEMS, a large player based on number of beneficiaries negotiating on its own behalf, has in recent years been able to negotiate lower hospital tariffs. Excluding network and low cost options, and comparing weighted tariff basket of the top 10 expenditure codes, we find GEMS and DH to consistently achieve the lowest average hospital tariffs across the 2012-2014 period, the period for which we have tariff data.

Facilities

45. Three hospital groups, Netcare, Mediclinic and Life have a combined market share of 83% of the national South African private facilities market in terms of number of beds and 90% in terms of total number of admissions⁴. With national Herfindahl-Hirschman (HHI) values of above 2 500, these national markets must be characterized as 'highly concentrated' by all internationally accepted criteria.
46. At the local level, 58% of the 195 local markets that the HMI has distinguished are also 'highly concentrated' as measured by the HHI and the Logit Competition Index (LOCI), which are both internationally accepted methods to assess market concentration at the local level.

4. Admissions are defined as any hospital consultation that incurred a facility fee payable to a hospital or hospital group.

47. The public hospital system does not provide a competitive constraint to private facilities and individual independent facilities are at a disadvantage when it comes to tariff negotiations, DSPs and ARMs. As independents, they also do not provide significant competitive constraints. A review of the impact of the exemption granted to NHN suggests that the smaller hospitals have benefited from the exemption.
48. One of the most important consequences of the dominance of the three large hospital groups is that no funder can afford not to contract with any one of the three big facility groups, or to totally exclude one of these groups from any provider networks. If the market were less concentrated, for example with 6 (still large) providers instead of the current 3 large groups, a funder would likely have the option not to contract with one of the groups, creating a completely different bargaining dynamic, to the benefit of beneficiaries.
49. Provider networks and/or DSPs are a promising tool to introduce competition among hospital groups, but are neutralised by dominance of hospital groups at a local level i.e. Life in the Eastern Cape, Mediclinic in Limpopo and Western Cape, Netcare in Gauteng, etc.
50. The high concentration ratio in the facilities' market at the national (as well concentration at the local level) and the large market shares of each of the three large hospital groups is therefore a major competitive concern.
51. A second competition concern is that symmetrical, highly concentrated supply market structures are generally conducive to overt and covert collusive conduct, for instance a low tendency to upset the status quo by introducing or embracing disruptive forms of new modes of delivery of hospital care.
52. A consequence is that the market is characterized by an absence of effective direct competition between the three big hospital groups. Except for limited pressure from DHMS (and DH) and lately GEMS, we have not seen evidence that other schemes and administrators exert sufficient buyer power on the hospital groups. The three big hospitals groups can continue in the knowledge that significant challenge is unlikely and this is probably the main reason the industry is not seeing innovation throughout the sector.
53. Profitability analyses of the three large hospital groups (Life, Mediclinic and Netcare) over the period under review shows that their profits have been consistent and sustained.
54. The facility licensing process has been found to be inconsistently applied by provinces, with bad consequences for all affected stakeholders. Inadequate use of hospital licensing legislation means the opportunity to collect useful data is missed daily.
55. A feature of the private hospital market is the number of beds available. In 2016, the national average ratio of beds/1000 population was 4.2 in the private healthcare sector (compared to 2.7 in the public sector). From 2010, the growth in registered beds in the private sector outstripped the growth in beneficiaries, implying an overall excess bed capacity within the private facilities market. There is no public data on bed occupancy rates in the private sector and various stakeholders use different (so non-comparable) methods to compute occupancy rates.
56. Within this context new licences are still approved. In spite of the high number of licences in issue, there hasn't been meaningful disruptive entry. Entry that currently occurs, facilitated by a will to ensure industry transformation and Black Economic Empowerment, has been to allow for new beds in an already oversupplied market by emerging players who often either get taken over by one of the big three groups, or are forced by finance institutions to join with one of the big groups to ensure that they get the financing they require to build new hospital facilities. The rest of the potential new entrants have no capacity to establish facilities and operationalize their licences.



Information asymmetry

57. As discussed above, inadequate information in the healthcare sector renders consumers exposed. They cannot easily choose between scheme options, nor between service providers. Consumers are subject to agents who operate in a market replete with perverse incentives. Information on health outcomes is essential to promote value based decision making.
58. There is no public data available regarding the cost-effectiveness of technologies and no guidance on what technologies may benefit health outcomes. One consequence is that this allows hospitals to purchase any and all technology and promote its use by making it available to practitioners, which inappropriately drives up costs where such technology does not provide value for money. Currently, there is no way to judge if technologies being used and promoted offer such value, but they have to be used to derive return on investment. Another consequence is that practitioners can make decisions that are not evidence informed.
59. A key problem underlying high and rising costs of care and medical scheme contributions is not primarily prices as such (although quasi-fixed at a non-competitive level), but overcapacity and over-investment in technology, higher treatment volumes and complex, intensive and expensive treatment methods than evidence may suggest is needed to benefit patients. Certainly, the absence of any health outcomes data makes any claims about the benefit of the level of intervention provided in the private market hollow. The conclusion that we have no evidence that this level of supply is necessarily beneficial is reinforced by the level of supply induced demand demonstrated in this healthcare sector compared to other healthcare sectors where good health outcomes are demonstrated. The direct and indirect costs of these are ultimately borne by the patient and beneficiary.

RECOMMENDATIONS

60. The complexity of this market requires several interrelated interventions, which are discussed in detail in the recommendations chapter (Chapter 10). The interventions we have proposed must be seen as a package and market failures may persist if a partial approach to the implementation of the recommendations is adopted.
61. Our recommendations aim at improving transparency, accountability and the alignment of interests of consumers and funders. We also aim to address the absence of measures of value, in particular healthcare outcomes, failures in pooling of funds, improved management of supply induced demand and methods to address concentration in the market. Our recommendations are aligned with the national policy trajectory towards Universal Health Coverage.
62. Part of our recommendations will be aimed at regulators who, we have concluded, are not as sensitive to core competition concepts as they should be.
63. Overall we recommend
 - 63.1.1. changes to the way scheme options are structured to increase comparability between schemes and increase competition in that market
 - 63.1.2. a system to increase transparency on health outcomes to allow for value purchasing
 - 63.1.3. a set of interventions to improve competition in the market through a supply side regulator