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HEALTH MARKET INQUIRY

Findings and Recommendations

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Outline

1. Introduction
2. Process of HMI
3. Characteristics of the Private Health Market
4. Findings
5. Recommendations and Progress
6. Health Exemptions received by the Competition Commission
7. Relevance to the National Health Insurance
8. Conclusion

Introduction

- Market Inquiries are a general investigation into the state, nature and form of competition in a market in terms of section 43B of the Competition Act, 89 of 1998, as amended (“the Act”)

- The Commission, acting on its own initiative, or at the request of the DTIC Minister, may conduct a market inquiry if it has reason to believe that any feature or combination of features of a market that impedes, restricts or distorts competition.

- The HMI was initiated in 2013 was Chaired by the Former Chief Justice, Sandile Ngcobo and conducted by an Independent Panel.

- The HMI was interested in the incentives which drive market behaviour and remedies to address to achieve affordable access to health.

Process thus far

- After extensive stakeholder engagement, market research conducted by the Panel, Technical Team and Expert Consultants, the HMI Final Report was published in September 2019, with a set of interrelated recommendations.

- Upon completion, the report was handed over the then Minister of Trade, Industry and Competition – tabled the Report to Parliament.

- In March 2020, the Commission presented the Final Report to the Portfolio Committee on Health. Further engagement hampered by the Covid 19 Pandemic.

- Several Stakeholder engagements were had, including with the NDOH, Council for Medical Schemes, to facilitate implementation of the recommendations.

- Limited progress has been made in implementation and many of the market failures identified by the HMI persist.

Characteristics of the Private Health System

- Dual system of provision between the private and the public sectors which perpetuates health inequalities.
- **Access to private market determined by socio-economic status**

- Focus of the HMI on the Private Health Market, largely characterised by:
  - High and rising costs
  - Significant overutilization
  - High market concentration both on the supply and demand side.
  - Declining Benefit cover, despite increasing premiums
  - No documented improvement in health outcomes that benefit consumers.
  - High profits reduce any incentive to innovate or change the status quo
  - Schemes compete on risk rather than pro-consumer metrics
  - Outdated regulations (PMBs at cost) and missing regulations (risk equalisation) has meant competition occurs on benefit design
  - Proliferation of incomparable benefit plans means consumers can't discipline the market

- Are these characteristics conducive to achieving positive outcomes?
  - Positive outcomes are those that benefit consumers
  - E.g. competition on price, quality, and health-outcomes

In general governments/regulators act in the event of failing markets.

Focus of the HMI

The focus of the HMI is the private healthcare sector which comprises a complex set of interrelated stakeholders who interact in various ways in the provision of care.

Analysis focused on three main markets in the healthcare sector, namely:

1. **Healthcare Facilities**: mainly hospitals, day hospitals and Specialist facilities
2. **Healthcare Providers:** Specialists and General Practitioners), and
3. **Funders Market:** Medical Schemes, Medical Scheme Administrators, and Brokers).

The analysis did not include Pharmaceuticals and Consumables.

Focus of the HMI (2)

Funders

Healthcare funders in the private sector comprise:

- Medical schemes, medical scheme
- administrators, managed care organisations (MCO), brokers and health insurers.
- Others
  - RAF, Compensation Funds
  - Out of Pocket Payments
- Brokers
  - Advise and guide consumers and employers in selecting private health insurance cover.

Reimburse for health services provided.

Practitioners

Provide healthcare goods and services

- Healthcare practitioners include:
  - general practitioners, specialists, nurses, pharmacists and other healthcare professionals.

Facilities

Provide healthcare general medical and surgical services

- Healthcare facilities include:
  - acute hospitals, sub-acute hospitals, day hospitals, specialised hospitals and healthcare centres and clinics

Provide health services To consumers

Findings Facilities

- At national level three big hospital groups dominate the market (**83.1% - beds & 86.9% - admissions**) and the majority of local markets (60%) are also highly concentrated
- NHN operating under an exemption through Section 10 of the Competition Act exert a **minor** competitive constraint, public sector and independent facilities do not exert competitive constraint
- Practitioners bring in patients to hospitals – the big three can attract Drs more easily – hospitals benefit from and facilitate high admission rates
- No measures of quality
- No demonstrable competition between facilities.

Practitioners – Findings

- Fee for service tariff setting – drives incentives for overserving
- "Price vacuum" (CC ruling on collective bargaining) but too many funders and practitioners for individual negotiations to be practical
  - Out-of-date codes and unilateral code changes
  - Practitioner associations quasi-collusive
- No reliable database of practitioners

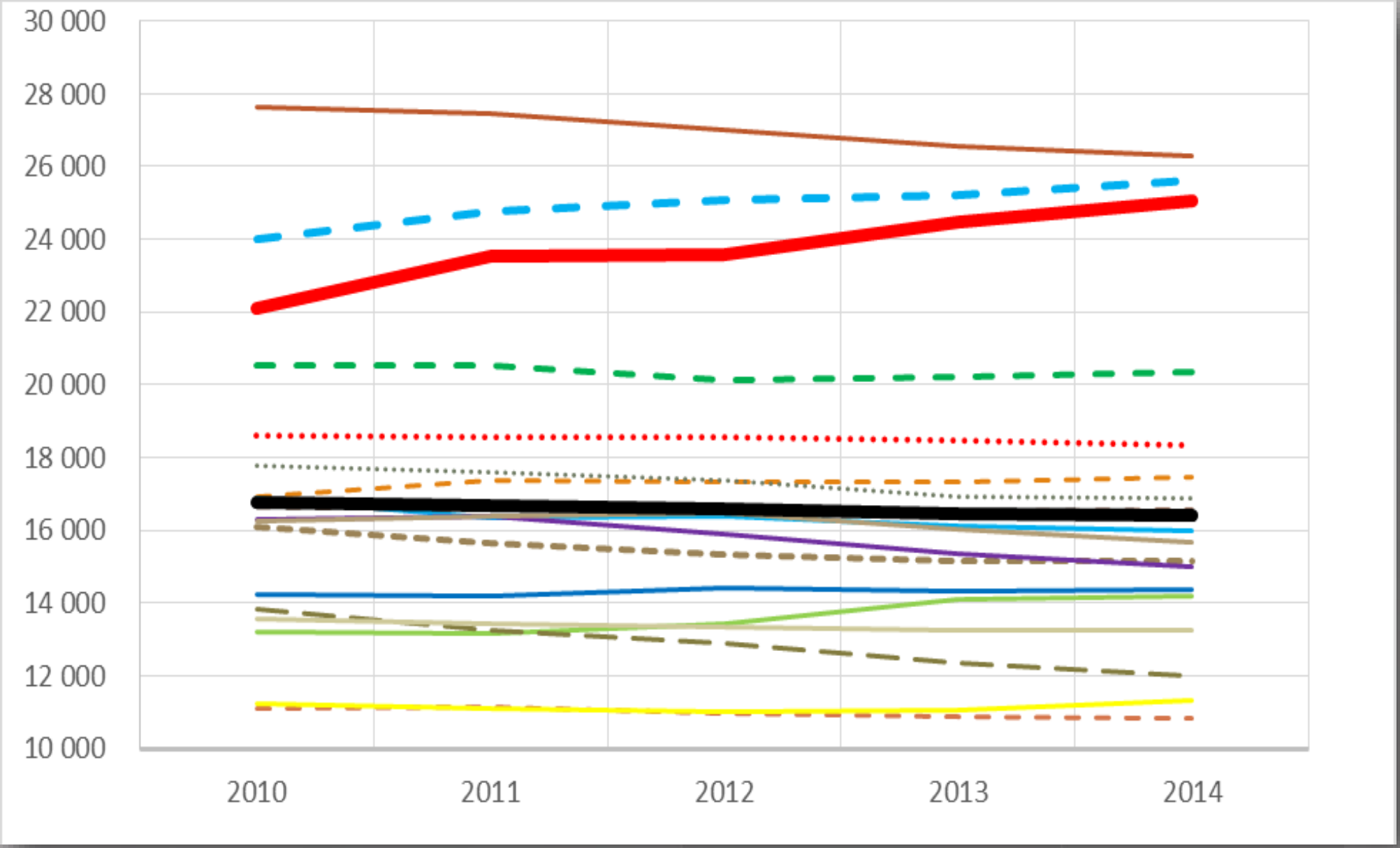
- Innovative models (multi-disciplinary teams) are hampered by:
  - HPCSA Rules
  - Funders
  - Practitioner Associations

Practitioners – Findings (2)

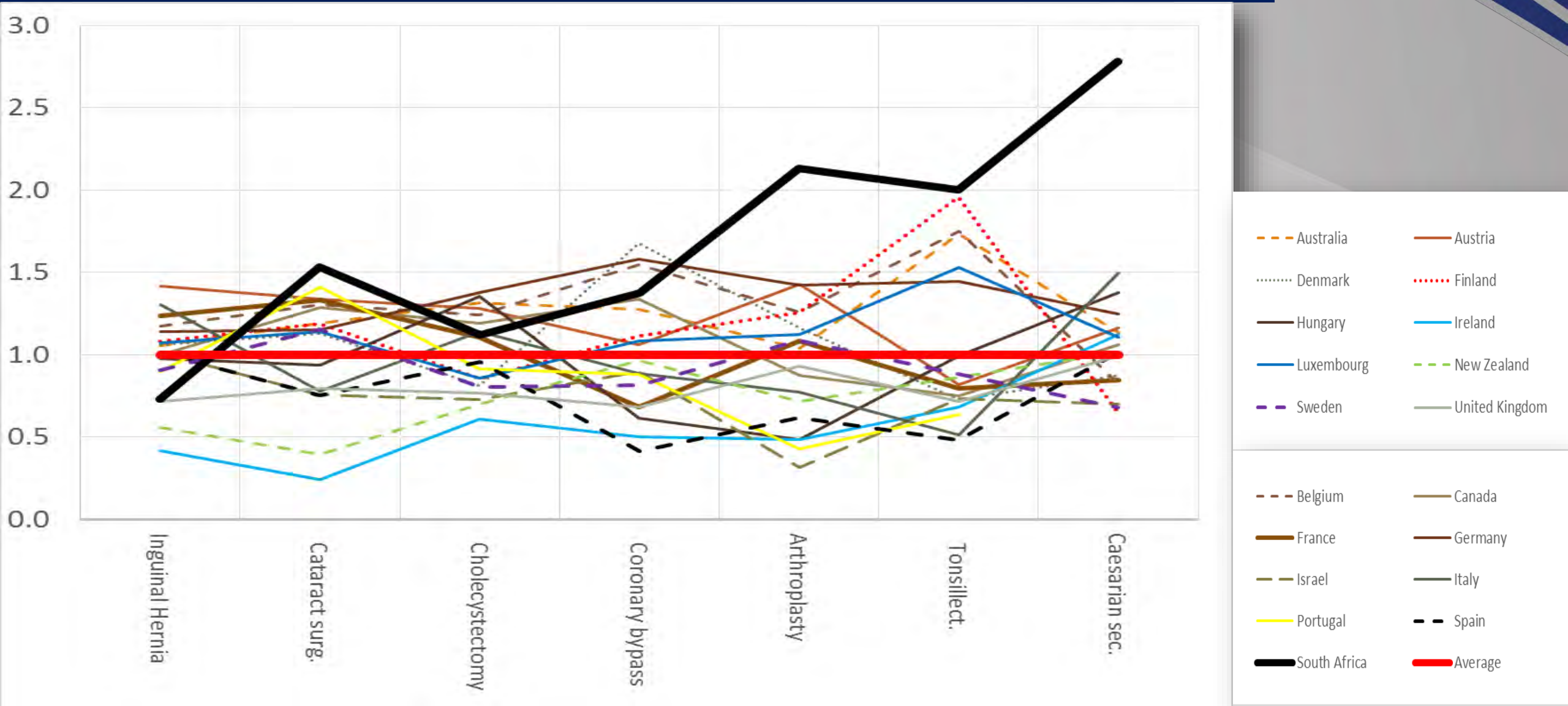
- No standardised measurement of quality and health outcomes
  - Consumers are uninformed and cannot compare
  - Practitioners cannot benchmark
  - Funders cannot contract on quality

- There is excessive utilisation driving healthcare costs
  - Not necessarily improving outcomes
  - More practitioners → more admissions
  - Current market incentives promote overutilization
    - FFS
    - Reimbursement of PMBs at cost - shifted market power to practitioners who ‘up-code’ and can set their own reimbursement level
    - Hospi-centric benefit design

Age-standardised hospital admission rates for South African private sector and a subset of 17 OECD countries



Relative age-adjusted admission rates (indexed to 1) for seven common discretionary admissions in South Africa and a selection of documented OECD countries.



Funders – Findings

- Funders operate within an incomplete regulatory framework which distorts competition
  - Open enrolment and community rating ✓
  - Risk-adjustment mechanism x
  - Mandatory membership x

- Competition occurs on risk → proliferation of medical schemes and benefit options – exacerbate information asymmetries
- Incomparable options means consumers are disempowered and cannot discipline the market
- Scheme and administrator markets are highly concentrated with unclear incentives.

Tariffs – Findings

- CCSA 2003/4 decision created market imbalance and tariff vacuum that prevails.
- Industry characterised by price uncertainty with regard practitioner services – and significant out of pocket payments
- Bilateral negotiations between funders and practitioners impractical
- Negotiations are largely characterised by FFS tariff increases rather than on ARMs
  - ARMs can benefit consumers (quality metrics) funders (certainty on cost) and providers (reward for risk)
- Where DSP networks have been successfully implemented benefits not transferred to consumers.

Key Recommendations

RECOMMENDATION	TO REMEDY	STATUS OF IMPLEMENTATION
• Supply-side regulation through some mechanism, a Supply Side Regulator Recommended	Unregulated supply side in the provision of services.	Not Implemented
• Healthcare facility planning (including licensing): Broader than certificate of Need to includes competition concerns in distribution	Fragmented, concentration and inequity in distribution of services.	Not Implemented, NB CON regulations outlawed by the Courts recently.
• Health Technology Assessments and Economic value assessments	Lack of economic value and technology which drives utilization.	Initiatives by Department of Health
• HPCSA must review ethical rules regarding: Multi-disciplinary practices, fee-sharing, and employment of doctors	Rules outdated and not responding to innovative and cost efficient models of provision of care.	Not Implemented
• NB: **Health services pricing – establishing of a Multilateral Price Determination framework. (Details next slide)**	The persistent lack of a tariff determination framework, perverse FFS price determination and out of pocket payments.	Not Implemented
• Standard Basic Package with the review of Prescribed Minimum Benefits and Clinical code reviews (NB)	Proliferation of medical schemes and benefits.	Process initiated by CMS but limited progress
• Practice numbering systems facilities and Practitioners (billing number)	A regulated and coordinated process of licensing practitioners and facilities.	Not Implemented

Tariff Determination – Recommendations

- Price Determination Vacuum persist and straining consumers: **declining benefits**, **lack of price certainty** and **huge out of pocket payments**.
- Multilateral tariff determination forum wherein funders and practitioners can collectively negotiate and determine pricing **URGENT**.
  - This should operate under the auspices of the NDOH
  - Set maximum PMB prices, and review of clinical codes.
  - Value and risk-based bilateral negotiations are supported
- Funders and facilities to continue with bilateral negotiations; but not business as usual
  - FFS contracts should be replaced with risk sharing models, including ARMs
  - These contracts to be submitted to CMS/NDOH for monitoring.

Health Exemptions Received

- Four Health Exemptions received by the CCSA under Section 10 of the Competition Act.
- The Exemptions cover practices that would otherwise be regarded as anti-competitive.
- Collective Negotiations between Funders and Providers for:
  - Defined Minimum Scale of Benefits
  - Determine Tariffs to cover PMB
  - Address clinical coding related to the defined scale of benefits
- These Exemptions in the main relate to the vacuum in Tariff Determination especially for Prescribed Minimum Benefits.
- Several Engagements held with the NDOH, CMS and Industry Stakeholders.
- An individual approach to these issues not desirable, thus a coordinated process through a Block Exemption likely to be effective.

Relevance to NHI

- The Competition Commission acknowledges and supports the overall objectives of the NHI in achieving a unified health care system for the country.

- It also acknowledges that healthcare markets may not be typical in that they:
  1) involve high stakes as it could determine whether someone lives or doesn't and but also makes consumers price insensitive,
  2) have large implications for the productivity of the population ('externalities') and so are of great importance to government, and
  3) involve many other market failures such as information asymmetries, which tends to impact healthcare costs

Relevance to NHI (2)

- Full implementation of NHI is still several years away - 2027 at the earliest
  – **A framework needs to be in place to enable a smooth transition.**

- A properly regulated and competitive private sector should lower costs, prices, and greater value-for-money

- Greater competition and efficiency will benefit state purchaser of services
- NHI requires supply-side providers to be properly regulated

- Fixing the failures in the private sector is a **necessary step** towards successful NHI implementation. These address the market power imbalances.

Relevance to NHI (3)

- International example of the UK NHS single-purchaser system, has public and private providers regulated by:
  - Monitor - independent supply-side regulator
  - Competition Authorities
- Netherlands has private providers regulated by both Health and Competition Authorities
- Critical that NHI fund transactions be done under the auspices of the Competition Act.

Relevance to NHI (4)

- Single basic benefit package focusing on primary and preventative health provides capacity to developing the defined package of comprehensive health services envisaged by NHI.
- Outcomes monitoring will allow for value-based purchasing, and to assess quality – existing institution Office of Health Standards Compliance does not extend to outcomes monitoring.
- MLNF sets a useful forum for price negotiation and price determination.
- Licencing and accreditation of service providers – 100% consistent with NHI
- Contracting Units (Cups) will be purchasing from private providers

Conclusion

- Many of the HMI recommendation not implemented.
- Four exemption applications before the CCSA to deal with tariff determination and coding, should be fast tracked.
- Important that work begins to implement HMI recommendations.
- These align with the objectives of the NHI.
- CC established an Advocacy team to continue stakeholder engagements to support NHI and implementation of HMI recommendations.

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THANK YOU