The Market Inquiry into the Private Healthcare Sector
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COMMENT ON THE DRAFT STATEMENT OF ISSUES FOR THE MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

Introduction

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Alexander Forbes Health welcomes the opportunity to provide a submission on the draft Statement of Issues for the market inquiry into the private healthcare sector and will support the Competition Commission through the inquiry.

Please note that as stated in the draft Statement of Issues, the contents of this document do not represent our settled views or findings, but rather additional points we feel could be added to the Panel's investigations.

Comments

This section provides comment on the draft Statement of Issues document, and where we feel additional points could be added. We have broken these down to tie into the sections specified in the draft document for ease of reference.

A. Framework

General

Paragraph 17 refers to possible reasons for increases in costs and expenditure in the healthcare sector. We agree with the reasons listed, but would like to expand on "imperfections in information" to explicitly investigate the following two points which may be increasing costs:

1. Poor health literacy levels may result in consumers not understanding their medical conditions. This may lead to the following:

    a. Not visiting a healthcare practitioner when necessary (i.e. not understanding the seriousness of a condition), which may lead to more expensive treatment as a result of complications and worsening of conditions.

    b. Not following the treatment plan provided by the healthcare practitioner due to a lack of understanding. This may result in the treatment being ineffective which could lead to further claims at a later stage.

    c. Visiting a healthcare practitioner when it is not necessary to do so. This could lead to unnecessary visits which will directly add to the costs incurred by the consumer.

2. Specifically with reference to medical schemes or medical insurance, many benefits are extremely complicated, leading to a lack of understanding on the part of members, which may increase out-of-pocket expenditure through co-payments and deductibles. With this in mind, we would like to request that the following two points be included in the inquiry:

    a. The non-standardisation of benefits between different medical schemes. While some of this is driven by medical schemes' efforts to differentiate their benefit offerings, we feel that it is also driven to a degree by the complexity of the regulations regarding Prescribed Minimum Benefits (PMBs). There are currently no standardised treatment protocols and formularies for the industry and as a result, schemes set their own treatment standards. This may lead to confusion among members, resulting in a lower level of understanding which could result in inappropriate cover and hence increase the total costs incurred.

    b. The method of communication of benefits. We acknowledge that this a substantial task as some of the complications built into the private healthcare system are as a result of an attempt to control overall costs and meet certain regulatory requirements. However, we feel that this is a key point for investigation. The method of communication could also be considered in line with the legislative requirements of Treating Customers Fairly.

In addition to the above, we suggest that the following be investigated as other possible reasons for increases in costs and expenditure:

- Fraud within the industry.

- Anti-selective behaviour of members, particularly with reference to the fact that individuals can choose when to join the medical schemes environment, and that this may only happen when they are ill.

Consumers

Paragraph 23 refers to the competition between medical schemes and other health insurance products. We believe that this is a critical point for investigation but would like to draw attention to the current draft regulations relating to the demarcation between medical scheme products and medical insurance products. Public comment is due in July 2014 and the Panel should bear these potential changes in mind when exploring these markets.

Paragraph 24 makes reference to the alignment of the interests of patients and providers. While we believe this is a valid point for investigation, we feel that the interests of patients/providers should also be considered in relation to the interests of financers of healthcare (i.e. medical schemes and medical insurance products). A common perception among consumers is that financers of healthcare try to avoid the payment of claims in order to "make more money". While many rules and protocols are built into these products, with the general intention being to control costs for the overall risk pool, a question that may need to be answered is whether some of these rules work against the long-term health of the individual. Our recommendation therefore, is to investigate the extent to which the interests of all three stakeholder groups (i.e. consumers, providers and financers) are aligned.

Paragraph 26 provides examples of how out-of-pocket expenses may arise for consumers. One of the examples is the requirement for consumers to make co-payments. We would recommend that this be split into two parts, specifically:

1. Co-payments or deductibles that form part of the benefit structure of the medical scheme or medical insurance product and should therefore be known before a claim is made (subject to communication and the level of understanding among consumers).

2. Co-payments that arise as a result of medical practitioners or facilities charging fees that exceed the reimbursement rates of the medical schemes, and which consumers may therefore not be aware of until after the claim has been incurred. In particular, this point would be considered with reference to the abolishment of the Reference Price List (RPL).

Financing of Healthcare Services

Paragraph 32 refers to the role of medical scheme brokers and whether their incentives align their interests with those of consumers. We agree that this is a valid point for investigation, but also feel that the role of brokers should be considered in terms of the following:

- The advice rendered which should allow better decision-making among consumers when choosing products.

- The assistance provided in correctly registering for medical scheme products.

- The assistance provided in helping consumers better understand their benefit entitlements, which may assist in avoiding unnecessary out-of-pocket expenses.

- The assistance provided for query resolution with medical schemes, which may result in savings for consumers in the case where claims are incorrectly processed.

- The support provided in lodging a formal complaint with the Council for Medical Schemes.

Paragraph 33 relates to regulation within the private healthcare sector, specifically with regard to the Medical Schemes Act. We believe that an investigation into the regulatory environment is crucial to understand the competition and market functioning within the sector as we believe that there are certain gaps in the current legislation that undermine the intention of this Act. We highlight some of these under "Theory of Harm 6", below.

Providers of Healthcare Products and Services

In *paragraph 35*, we recommend that nurses are specifically added to the list of healthcare practitioners.

In *paragraph 39*, we suggest adding in an investigation into how GPs and specialists set their prices. As there are currently no guideline tariffs in place, we feel that this is an important feature of the market. One way in which prices would be set is through negotiations with medical schemes and/or administrators, but in the absence of negotiations, how do these healthcare practitioners determine a "fair" price? This is covered to some extent in paragraph 42.

Paragraph 43 refers to the market for pharmaceuticals and consumables. We would like to recommend that biological drugs as well as new, experimental drugs be included in this analysis as they are commonly recognised as cost drivers within the private healthcare sector.

The Role of the Public Healthcare Sector

Regarding the inclusion of the public sector in *paragraph 46*, we understand that the inquiry focuses on the private healthcare sector, however one point that may be important to consider is that the perceived poor quality and lack of accessibility and availability of services in the public healthcare sector may drive individuals towards the private sector, thereby increasing demand for these services and hence prices.

B. Theories of Harm to Competition

Theory of Harm 1: Market power and distortions in healthcare financing.

Under this theory of harm, one of the market power relations or distortions is stated as the "market power of medical scheme administrators over medical schemes". We agree that this should be included but also recommend that the alternative be investigated, i.e. market power of medical schemes over medical scheme administrators.

In addition, market power relations or distortions relating to managed care organisations should be considered in relation to the other stakeholders.

With specific reference to the relationship between medical schemes, administrators and healthcare facilities, contracts such as Alternative Reimbursement Models (ARMs) and capitation arrangements should be considered.

Theory of Harm 2: Market power and distortions in relation to healthcare facilities.

We are comfortable with this theory of harm as described in the draft Statement of Issues.

Theory of Harm 3: Market power and distortions in relation to healthcare practitioners.

Within this theory of harm, the current quality of education as well as access to education in order to become a healthcare practitioner could be investigated to assess the impact to the supply of practitioners to the country.

Theory of Harm 4: Barriers to entry and expansion at various levels of the healthcare value chain.

Regarding barriers to entry for healthcare practitioners, we feel that an important point to investigate is whether the premiums payable for professional indemnity insurance are excessively high and to what extent these costs filter through to the costs incurred by consumers.

In addition, a worthwhile investigation would be the potential barriers to entry caused by current legislation and regulations, with particular reference to the approval and accreditation of medical schemes, medical scheme administrators, managed care organisations, medical insurance products and medical scheme brokers, among others. The current regulations may be too prohibitive, causing a barrier to entry, but alternatively may be too lenient in parts.

Additionally, there is a view that medical scheme brokers unfairly distort competition in favour of specific schemes and administrators. The inquiry should investigate this in light of the fact that all medical schemes pay regulated levels of commission (based on a percentage of contributions) and that the entry requirements for brokers are not as extensive as some other parts of the healthcare value chain.

Theory of Harm 5: Imperfect information.

We are comfortable with this theory of harm as described in the draft Statement of Issues.

Theory of Harm 6: Regulatory framework.

We agree that there are deficiencies and unintended consequences in the current regulatory framework. Some specific areas that we would recommend for investigation include:

- The current list of PMBs. The cost of this minimum benefit package is still too high for many consumers to afford. The Panel could assess whether the list could be shortened to include fewer conditions and treatments, or whether the focus of the PMBs could be changed to preventative and primary care to better align with the National Health Insurance (NHI) objectives.

- The lack of use of the Risk Equalisation Fund (REF). The intention of this Fund is to equalise the costs of PMBs between medical schemes, however, without the REF in use, medical schemes with poorer risk profiles are at a significant disadvantage when it comes to the pricing of benefits.

- The lack of guideline tariffs and prices may lead to abuse in the system where some healthcare practitioners charge excessive amounts for PMB conditions as medical schemes are obliged to fund for these in full.

- The lack of mandatory membership of medical schemes (or a medical insurance product) may be leading to anti-selective behaviour where individuals only enter the financing system once they are in need of healthcare services. This may be undermining the risk-pooling concept of medical schemes.

- An investigation into whether the regulations for medical schemes and medical insurance products complement or contradict each other could be performed. This would have to be considered with due regard to the current draft regulations relating to the demarcation between these products.

Concluding Remarks

Alexander Forbes Health supports the Competition Commission's inquiry into the private healthcare sector and with the exception of the above comments we are comfortable that the draft Statement of Issues is sufficiently comprehensive to meet the overall objectives of the inquiry.

This commentary was compiled by ***Technical and Actuarial Consulting Solutions (TACS)***, a division of Alexander Forbes Health (Pty) Ltd, in conjunction with the ***Research and Product Development (R&PD)*** division of Alexander Forbes Financial Services.

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