Free Market Foundation

Submission on Draft Statement of Issues

Draft Statement of Issues - Competition Commission Enquiry into the Private Healthcare Sector

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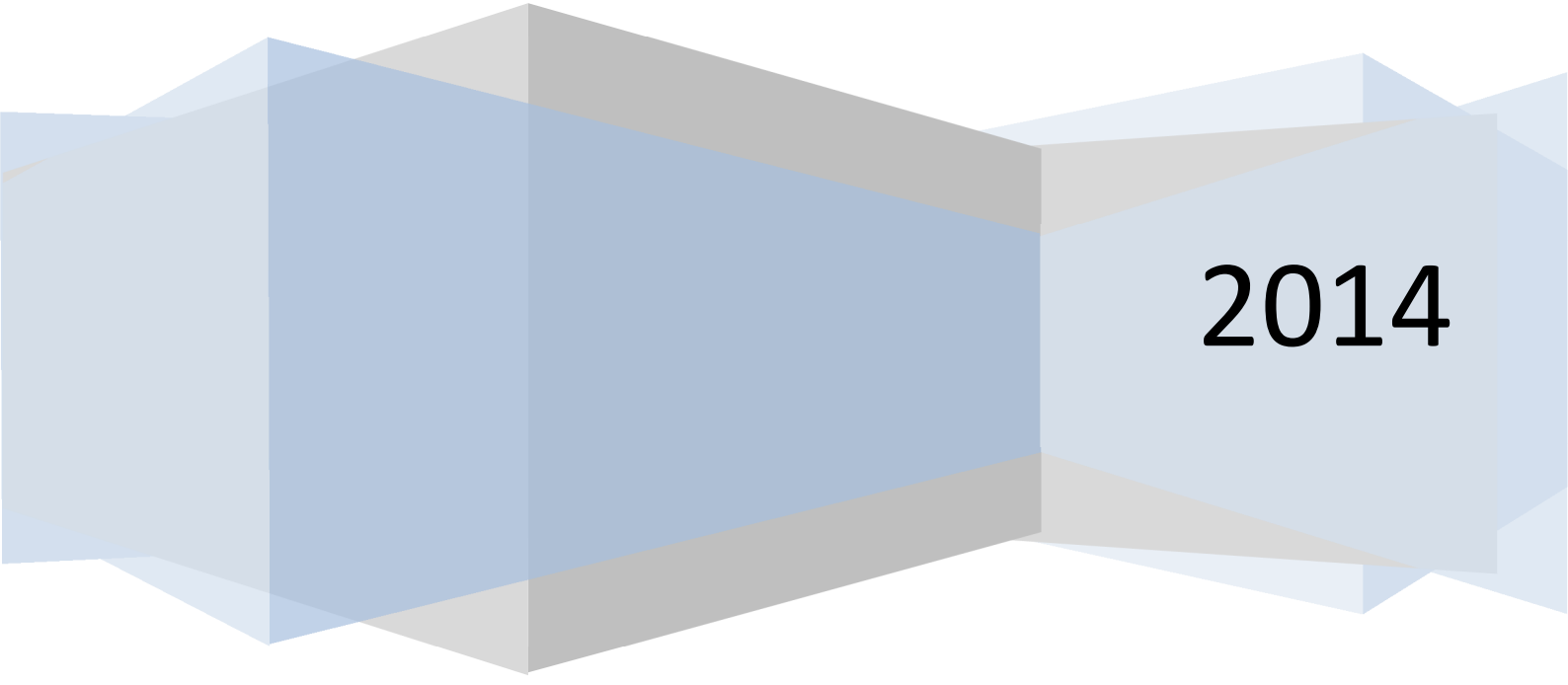

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Executive Summary

All across the globe governments are grappling with the question of how to contain healthcare costs. This is not a peculiar feature of private healthcare but is rather a systemic issue that has largely resulted from the fact that global incomes are rising at an unprecedented rate. As a result of rising incomes people are demanding more and better healthcare services, which naturally leads to greater healthcare expenditure since healthcare is what economists refer to as a "superior good" – when income goes up, people not only consume more health care, they actually increase the per cent of their income they spend on health care. Since most governments dominate healthcare sectors this has become a "problem" since spending in one area necessarily comes at the expense of other areas because governments have a relatively fixed budget. As a result of rising incomes people are also living much longer than ever before and this has resulted in a rising burden of chronic disease that requires more healthcare expenditure. The South African private healthcare sector is not unique and healthcare expenditure is also bound to increase. However, the South African private healthcare sector is one of, if not the most, regulated sector in the South African economy where government instituted controls are pervasive. These government imposed regulations serve to restrict competition and should be amended with immediate effect in order to open the market and allow increased competition within the sector, which is the surest path to lowering prices for consumers without causing serious harm to the enduring supply of health care.

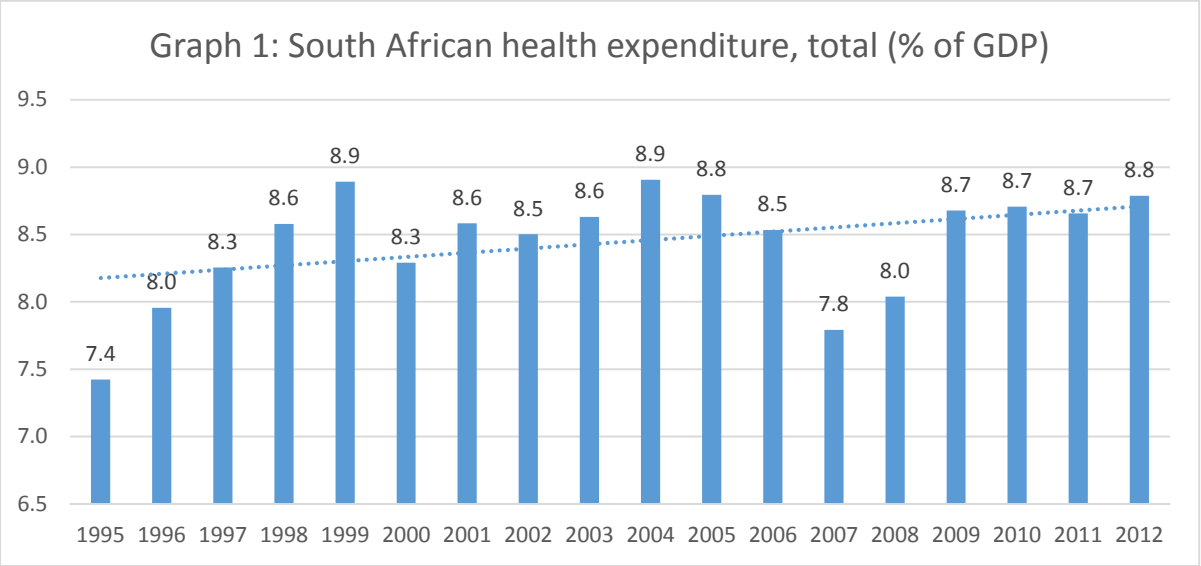
About the Free Market Foundation

The Free Market Foundation is an independent public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships. The Free Market Foundation (FMF) has a dedicated Health Policy Unit (HPU), which is committed to promoting a sound economic and business-friendly policy approach to the provision and funding of health care. The FMF considers the private supply of competitive health-care services and the incremental extension of private funding to be the most effective method of supplying high quality health care to the entire South African population.

Introduction

All across the world healthcare systems are under pressure from rising costs. As a result, spending on health care has been elevated to one of the main policy issues under examination by most advanced country governments. Increased government expenditures on healthcare is putting pressure on government budgets as health consumes larger proportions of fiscal revenue. The OECD states, "The ratio of public health expenditure to GDP has been rising steadily for several decades. Since 1970, on average across OECD countries, the expenditure to GDP ratio has increased by 3.5 percentage points to reach around 7 percentage points in 2010". The OECD notes that the drivers of public health care expenditure are demographic and non-demographic. "Demographic drivers relate broadly to the age structure of the population and the evolution of its health status, while a non-demographic driver is income".

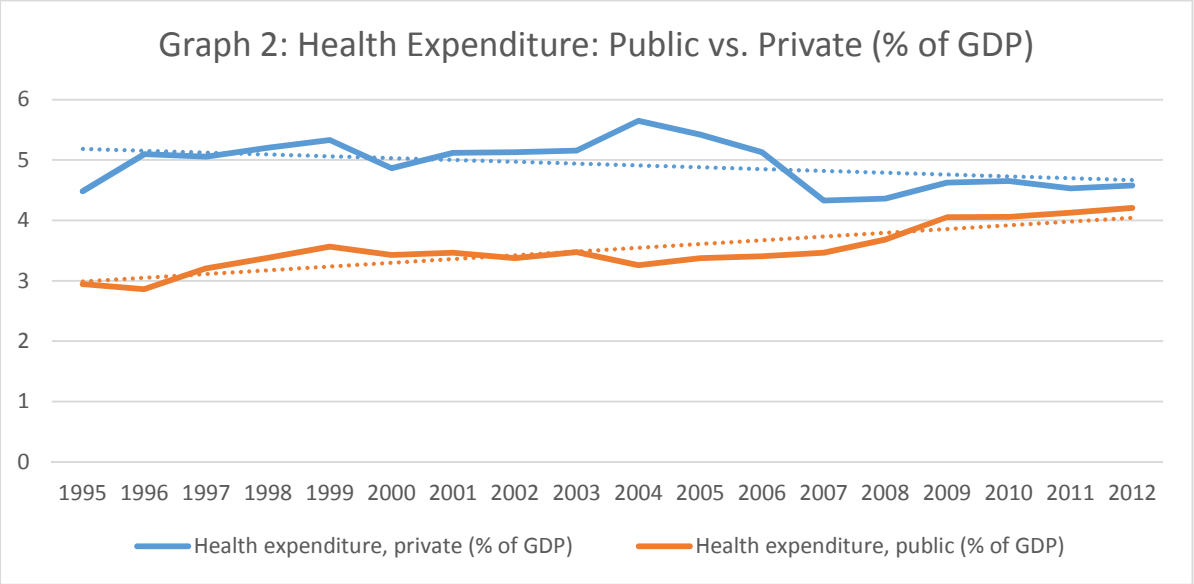
Health expenditure in South Africa has risen from 7.4 per cent of gross domestic product (GDP) in 1995 to 8.8 per cent in 2012. Although this is not as steep as other countries there is a clear upward trend in health expenditure as proportion of total GDP. Rising health care expenditure in South Africa is thus not a unique phenomenon and is certainly not only confined to the private sector (see Graphs 1 and 2 below). In 1995 public health expenditure as a percentage of gross domestic product (GDP)[1] was 2.9 per cent. By 2012 this had increased to 4.2 per cent. In contrast, private health expenditure as a proportion of GDP[2] has remained relatively constant at 4.5 per cent of GDP over the period 1995-2012.



Source: World Bank, World Development Indicators

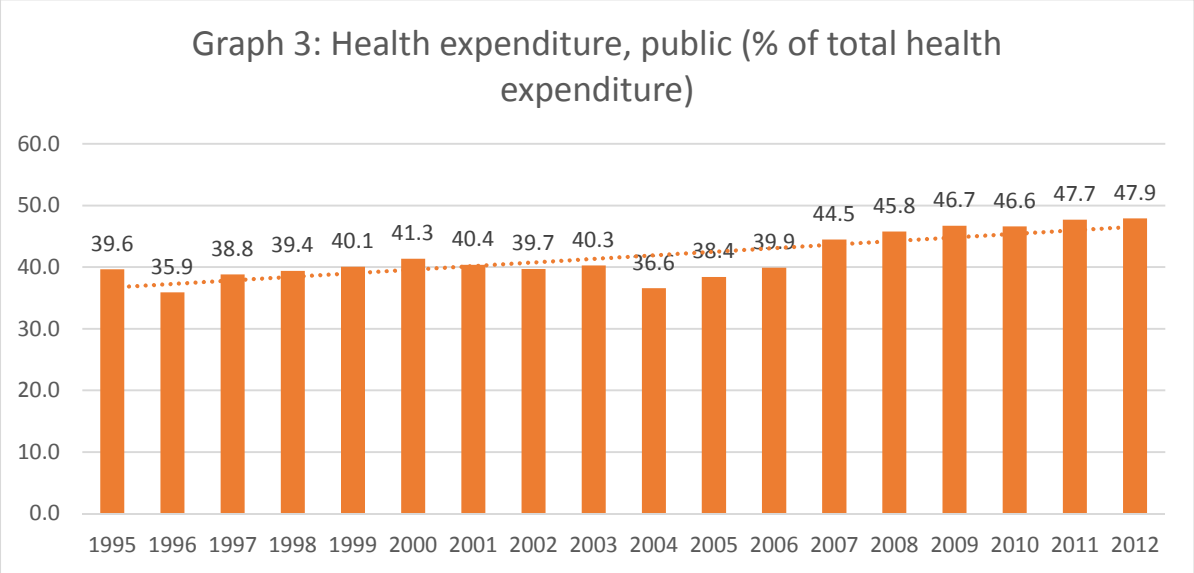
[1] Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

[2] Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.



Source: World Bank, World Development Indicators

Not unexpectedly, given the rising expenditure patterns in the public sector, public health expenditure as proportion of total health expenditure[3] has been steadily increasing. Since 1995 public health expenditure as a proportion of total health expenditure has risen from 39.6 per cent to 47.9 per cent in 2012 (see Graph 3 below).

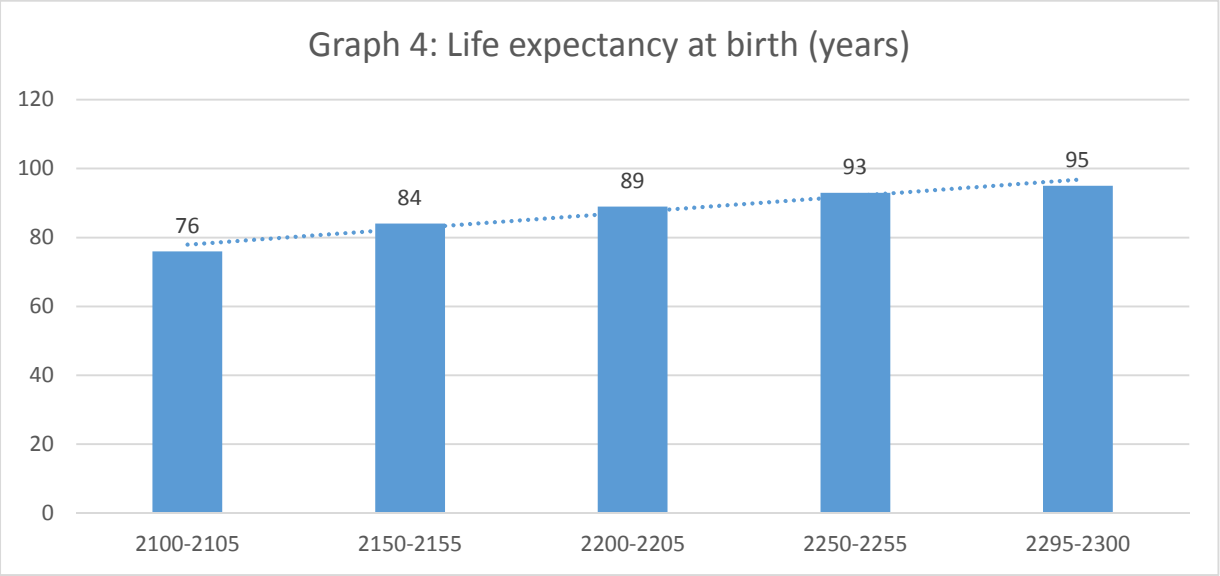


Source: World Bank, World Development Indicators

Like all other nations across the globe average life expectancy in South Africa is increasing. An important feature of an aging population is that one can reasonably expect healthcare expenditure to rise. In South Africa life expectancy at birth has increased from 52.7 years in 2002 to 59.6 years in

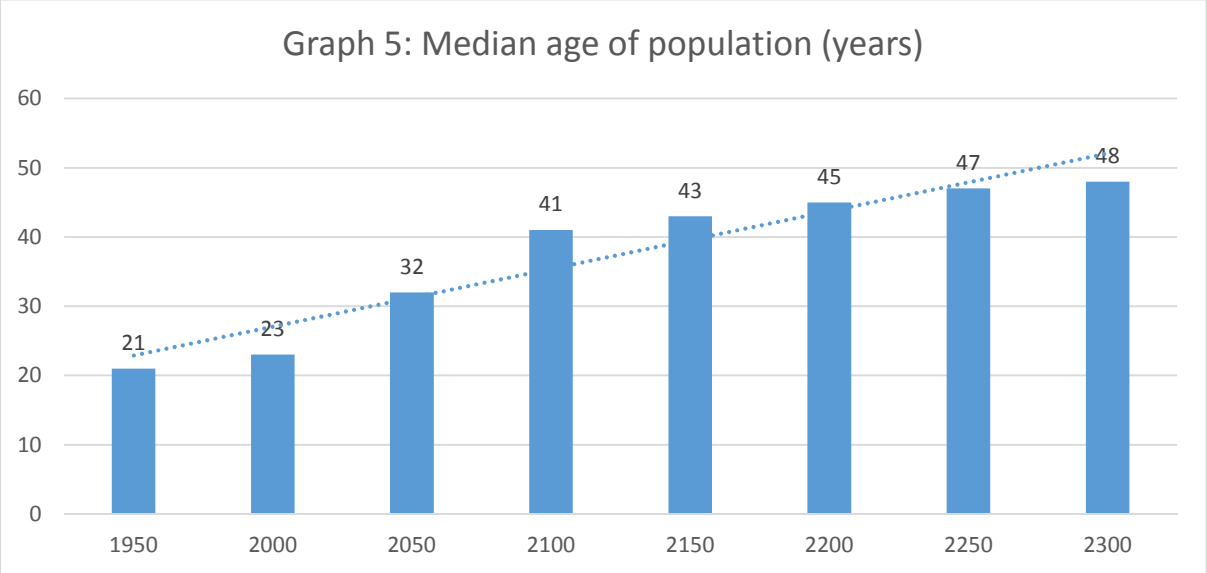
[3] Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organisations), and social (or compulsory) health insurance funds. Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

2013.[4] Moreover, according to the United Nations Population Estimates life expectancy at birth will continue to rise (see Graph 4 below). Life expectancy at birth is expected to increase from current levels to reach an estimated average of 76 years by 2100. It is anticipated that life expectancy at birth will continue to rise after 2100 but at a slower rate reaching 95 years by the year 2295.



Source: United Nations, 2004

As a result of South Africa's aging population the median age is expected to increase from 23 years in 2000 to 32 years in 2050 and 48 years by 2300 (see Graph 5 below). This aging trend has important implications for healthcare costs.

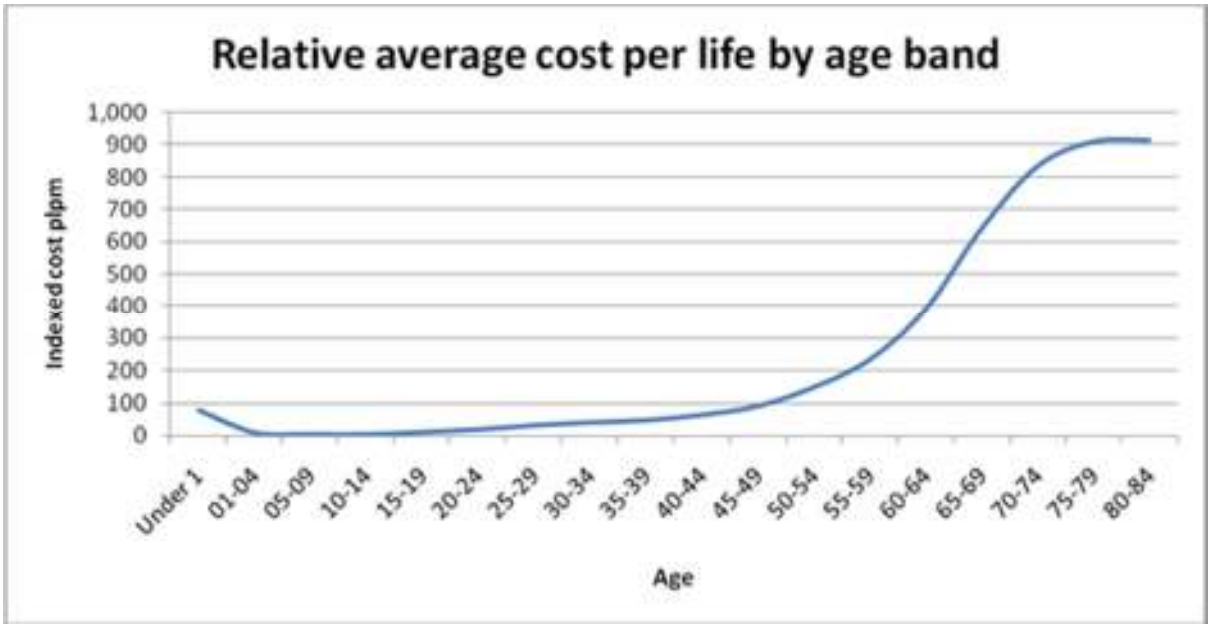


Source: United Nations, 2004

As people age there is an increased probability that they will require chronic care which in turn raises expected medical care expenditure. New innovative technologies that cause people to live longer also raise the price of medical care. According to South African industry sources, Graph 6 below provides

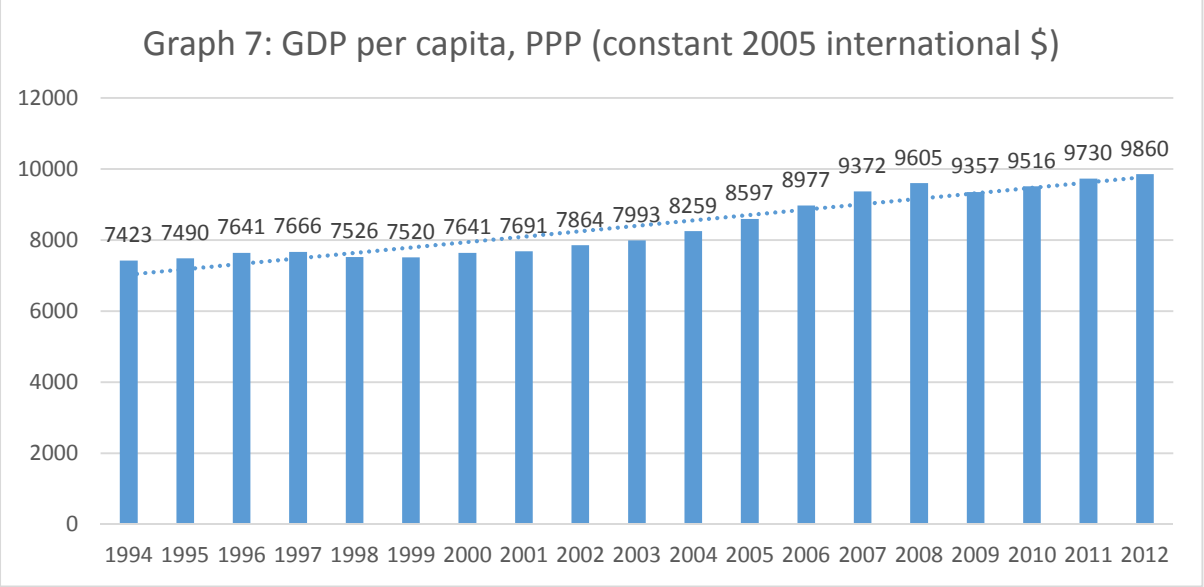
[4] World Bank, World Development Indicators.

a graphical representation of expenditure on health care disaggregated by age group. The vertical axis represents an indexed cost per life per month (plpm) and the horizontal axis represents age cohorts in years. In general terms, an 80-84 year old individual has monthly average costs about nine times those of a 45-49 year old. Similarly, a 5-9 year-old individual has a cost of about 3 per cent of the total costs that a 45-49 year old individual can expect to pay.



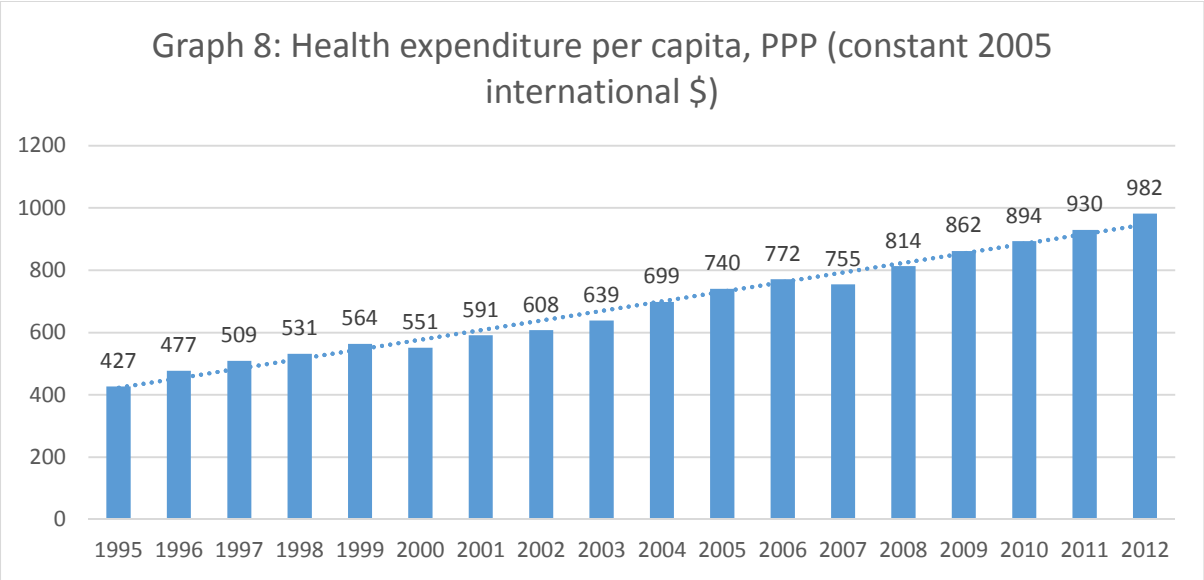
Source: Various industry sources

Health spending also tends to rise with income because health care is what economists refer to as a "superior good". Expenditure on superior goods is not only positively correlated with income but as income goes up people not only consume more health care, they actually increase the per cent of their income they spend on health care. As can be seen from Graph 7 below South Africans are getting richer and as they do real health expenditure per capita is increasing (see Graph 8 below).



Source: World Bank, World Development Indicators

Real health expenditure per capita (measured on a purchasing power parity basis) has more than doubled, increasing by approximately 130 per cent, over the period 1995 to 2012.[5]



Source: World Bank, World Development Indicators

[5] Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in international dollars converted using 2005 purchasing power parity (PPP) rates.

Detailed Submission

According to the Competition Commissions Statement of Issues (SoI), the decision to initiate the inquiry is due to "rising healthcare expenditure" in the private sector. And "These increases in prices and expenditure frame the decision to initiate the inquiry". However, as was demonstrated in the introduction, health expenditure all across the world is increasing and it is certainly not a feature that is unique to the South African *private* healthcare sector. Although it is not possible to obtain an accurate picture of disaggregated expenditure patterns in the public sector, given the fact that public health expenditure as a proportion of gross domestic product (GDP) is increasing, it is reasonable to assume that the public sector is also facing increased cost pressures. It is often claimed that the private sector only caters for 17 per cent of the population, although we dispute this simplistic claim, if we grant for a moment that this is true, it would appear that the inordinate focus on the private sector is unwarranted.

The SoI states,

> *"24. Patients are often less well informed about matters such as diagnosis and treatment than the providers who make these decisions. In cases where urgent medical care is required, the patient is even less likely to play any role in decisions regarding their own treatment. The Panel wishes to understand how decisions made by and/or on behalf of patients are affected by prevailing incentives, availability of information, power relations between patient and provider, and the fact that payment for treatment is often made by medical schemes on behalf of patients. In particular, the Panel wishes to understand the extent to which interests of patients and interests of providers are aligned with good healthcare outcomes. The Panel seeks to understand whether there are any factors bringing about a misalignment in this regard".*

Critics of private healthcare have often emphasised the possibility of market failure due to "adverse selection" in the private medical aid markets and imperfect (or asymmetric) information in healthcare in general. Although this situation is not unique to healthcare the result has been to introduce policies that favour more government regulation and less consumer choice. Indeed policymakers have generally acted as if adverse selection was a dominant reality and has supposedly provided legitimacy for all sorts of regulatory interventions and policies that have pursued ideas such as social solidarity. These polices favour equity over efficiency and prevent actuaries from devising policies that provide sticks and carrots for individuals, such as charging variable premiums based on an individual's behaviour and lifestyle choices. (see response to SoI point 33 below).

Point number 25 of the SoI states,

> *"A distinguishing feature of the private healthcare sector is that there is often a third party, such as a medical scheme or an insurance company, who makes payments on behalf of patients. Patients are therefore less likely to be constrained in making decisions about the affordability of services than they would be if they had to pay directly for services. The Panel wishes to understand how this affects both the incentives of patients and competitive outcomes in the sector".*

There is a certain amount of moral hazard involved with any third party payments and this is true for all insurance based policies. This is why it is essential that medical schemes tailor make policies as far as possible to suit individuals' needs. For example, policies that predominantly cover accidental risks, tend to appeal to younger people and generally have higher co-payments but lower premiums. In

contrast, policies covering mainly chronic conditions tend to appeal to older people and have lower co-payments but higher premiums.

The SoI states,

> *"26. The requirement to make out-of-pocket payments may arise when patients are required to make co-payments, when a patient's scheme savings or benefits are exhausted, or when a patient has no scheme or insurance cover at all. The requirement to make co-payments, or the extent and level of co-payments, will influence consumer choice. Specifically, consumers may select schemes based on their terms and conditions regarding out-of-pocket payments. The Panel wishes to understand the circumstances under which a system of out-of-pocket payments has arisen in South Africa, what this means for the welfare of consumers, and the effect, if any, of out-of-pocket payments on competition".*

Co-payments are an essential cost containment feature of medical aid schemes that prevent moral hazard. A co-payment is often a fraction of the actual cost of the medical service but is set at a level sufficiently high to prevent people from seeking care that may not be necessary. Without co-payments patients will seek care more regularly than they otherwise would if they were paying for some or all of the cost of care. Co-payments thus form a vital function in controlling costs and different medical aid options are devised to cater for different medical requirements (see response to point 34 below).

The findings from one of the largest surveys ever conducted, the landmark RAND Health Insurance Experiment (HIE) in the United States, are instructive. The HIE remains the only long-term experimental study of cost sharing and its effects on service use, quality of care, and health. The HIE was a large-scale, randomised experiment that tracked 2,750 families involving over 7,700 individuals' medical related activities for over a decade. The key findings of the experiment were as follows:

1.) Participants who paid for a share of their health care used fewer health services than a comparison group given free care
2.) Cost sharing reduced the use of services but did not significantly affect the quality of care received by participants
3.) Cost sharing in general had no adverse effects on participant health

These findings demonstrate that cost sharing initiatives such as co-payments, deductibles etc. are an essential cost containment feature and do not affect patients' health outcomes.

Financing of healthcare services

> *29. Administrators play an important role in negotiating tariffs and reimbursement mechanisms with providers of healthcare services. They are confronted with a fragmented market and must negotiate with disparate providers. What are the implications of the relative sizes of medical schemes and/or administrators on this negotiating process, on market structure, on competition and sustainability of the sector, and on bargaining outcomes? Further, what is the impact of the complexity inherent in the sector on the ability of medical schemes and/or administrators to make comparisons and informed decisions about the price and quality of various services during the negotiation process? The Panel wishes to understand the effect of the availability of information on competitive outcomes as they pertain to the role of medical schemes and/or administrators in the bargaining process.*

The 2004 Competition Commission ruling that prevents medical schemes from negotiating prices with service providers must be reversed as a matter of urgency in order to increase the bargaining power

of medical schemes so that they can offer reduced prices to consumers. If they are prevented from negotiating, they must also not be expected to 'pay in full' the fees charged by service providers for services that fall under the so-called Prescribed Minimum Benefits (PMBs) described below. This has the potential to exhaust an entire pool of savings and render the medical schemes insolvent, and are thus harmful to all individuals covered by the affected medical scheme options.

> *30. Administrators and/or medical schemes design benefits, negotiate tariffs, and process claims for a wide variety of services and a large number of providers. They need good quality information to do this effectively. Should there be trade-offs between, on the one hand, coordination in organising and publishing this information and, on the other, competition and rivalry among providers and medical schemes? The Panel wishes to understand these trade-offs, if any, the role of standardisation (or lack thereof), and the impact of regulatory intervention on competitive outcomes.*

Information is a good like any other and plays a role in competition between providers of goods and services. Spending on superior information can give a provider a temporary competitive advantage over other providers but it also provides a spur to competitors to enhance the quality of their own information. Standardisation of information, especially through regulatory obligation, will halt or retard the process of information enhancement, reduce the quality of information in the longer term, and reduce competition between providers. Government intervention in the information field inevitably reduces innovation and progress.

> *33. The Medical Schemes Act, 131 of 1998, protects consumers from catastrophic healthcare expenditure, while preventing schemes from discriminating against high-risk members or cherry picking members who are less likely to become ill and are thus low risk. The Panel wishes to understand how risk pooling arrangements, risk equalisation, other risk sharing mechanisms and the rules governing them affect competitive outcomes in the sector. The Panel also seeks to understand how the demographics of scheme membership influence the costs of private healthcare.*

In 1998, government adopted the Medical Schemes Act (MSA) to introduce "social solidarity" in the private medical schemes market. The Act ushered in four main amendments: open enrolment, community rating, statutory solvency requirements, and a comprehensive package of hospital and outpatient services that all schemes are compelled to provide regardless of the individual's age, sex or health status. This minimum package of benefits is commonly referred to as prescribed minimum benefits (PMBs). Each of these amendments resulted in an increase in the cost of providing medical scheme coverage, which invariably needed to be borne by the consumer.

Open enrolment is the practice whereby medical schemes are compelled to accept all individuals, regardless of age, sex or health status (subject only to their income and number of dependents or both). In order to reduce the probability of selecting high-risk individuals, schemes were permitted to apply waiting periods and penalties to those members over a certain age joining a scheme for the first time. The Act made it compulsory for every scheme to charge the same premium to every member within an option, despite their age or state of health, a practice commonly referred to as community rating. The Act also introduced statutory solvency requirements, which stipulate the minimum amount of accumulated funds that each scheme should hold as a reserve. Finally, the Act of 1998 made it compulsory for every scheme to provide PMBs.[6]

[6] See the Medical Schemes Act of 1998 (Act no. 131 of 1998) for a list of the PMBs available at: http://www.doh.gov.za/docs/regulations/1999/reg1262.pdf

Community rating and open enrolment

Under the Medical Schemes Act of 1967, community rating was legislated, that is the practice whereby all insurers are forced to charge the same price to every member of a scheme regardless of age, sex or health status, which meant that a 65-year old individual was charged the same premium as a 25-year old. An older person is charged less than actuarially necessary to pay their expected health care costs while a young person is charged more than is actuarially necessary. Under this system, healthy people are charged more so that sick people can be charged less.

This so-called act of 'social solidarity' has the effect of driving lower-income and healthy people out of the market or preventing them from even entering the market. The consequence is that the risk pool of insured people becomes smaller and less healthy, driving up contribution levels and making health insurance unaffordable. This vicious cycle could eventually lead to a situation where the entire health insurance market could disappear altogether.

In contrast, when schemes are permitted to "risk rate" individual's health coverage providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. In cases where the individual is paying the full premium for coverage, health coverage providers will charge a higher premium to people who are older to recognise the higher expected costs. People seeking health insurance therefore pay premiums commensurate with their expected health risks.

With risk rating, the responsibility for an individual's health is placed directly in their own hands, whereas the theory of social solidarity, in practice, is neither efficient nor effective. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older people with higher expected costs, raising the average cost and making coverage in the pool less attractive to younger people. The practise of selecting high-risk individuals is commonly referred to as adverse selection.

For obvious reasons, people who know that they are in poor health, are more likely to seek health insurance than people in good health. A pool subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to rise continually until the scheme becomes unviable and everyone in the scheme loses out – a process commonly referred to as the 'death spiral'.

In 1998, the SA government introduced the system of community rating with open enrollment, statutory solvency requirements and prescribed minimum benefits. Open enrollment further exacerbates the problems of community rating by making it compulsory for medical schemes to accept high-risk individuals, yet compelling them to charge the same premium as they charge low-risk individuals. It should be noted, however, that in order to accommodate the risks involved with the adverse selection of high-risk individuals, medical schemes are allowed to apply waiting periods and penalties to members over a certain age joining a medical scheme for the first time. But this merely acts as a 'band aid' to overcome the much wider shortcomings of the community rating system.

As a result of the introduction of the Medical Schemes Act of 1998, a substantial number of medical schemes in the market consolidated since they could no longer compete effectively on price. The number of schemes dropped by one-third from 144 in 2000 to 92 in 2012, which translates into an average rate of decline of four medical schemes per year over the 12 year period.

Despite the reduction in the number of medical schemes, there has been a 26.9 per cent increase in the number of lives covered by private medical aid schemes, from 6.7 million to 8.7 million, over the period 2000 to 2012. In addition there are an estimated 1.8 million people covered by private health

insurance contracts. This is primarily due to the fact that South African's are getting richer and as a result there is an increased demand for quality healthcare. As noted previously, expenditure on health care is predominantly determined by age. When one considers SA's aging demographic profile, it is difficult to imagine how a system based on community rating could be considered sustainable.

The average costs of premiums can be expected to rise as the population ages in order to reflect the changing demographic profile. This may cause individuals at the margin to drop out of schemes or act as a *de facto* barrier preventing young individuals from entering schemes and have the unintended consequence of raising the risk profile of the scheme, leading to the death spiral.

In the absence of community rating, individuals will pay premiums commensurate with their risks. When people take responsibility for their own lives, private medical schemes will be in a position to offer positive incentives such as reduced premiums or special discounts for members and policyholders who exercise regularly drink in moderation, or do not smoke, etc. Similarly, private health insurers could create negative incentives or sticks by charging higher premiums to policyholders who smoke, drink excessively and are obese.

To the extent that medical schemes are compelled to move away from economic and actuarial realities, they will be creating a situation that will be unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. Government should not lock people into a pre-conceived notion of what is currently regarded as ideal. Changes will occur over time and, as the population ages, premiums will be forced to rise.

Prescribed minimum benefits

Prescribed minimum benefits (PMBs) are minimum benefits which, by law, must be provided to all medical scheme members, regardless of which option they are enrolled in and include the provision of diagnosis, treatment and care costs, commonly referred to as Diagnosis and Treatment Pairs (DTP).[7] Initially, PMBs consisted of a basket of 270 conditions, mostly hospital based, which had to be funded in full by medical schemes. In 2001, the Act of 1998 was amended and a further 25 chronic conditions were added to the list of PMBs.[8] The Council for Medical Schemes notes, "By making these benefits mandatory, the government… hopes to stamp out attempts by schemes to rate members on the financial risk they pose to a scheme because of the state of their health".[9]

By forcing medical schemes to provide a comprehensive package of minimum benefits, the PMB regulation attempts to stop risk selection through product design. Policies that predominantly cover accidental risks, tend to appeal to younger people and policies covering mainly chronic conditions, tend to appeal to older people. However, the government's list of PMBs applies to all individuals regardless of age, sex or health status and whether or not they actually need the cover. Not surprisingly, these minimum benefits raise the predicted costs of every option, thus reducing the probability of people seeking private medical coverage at the low end of the market and causing people at the margins to leave schemes. As a result of PMBs, medical scheme actuaries are prevented

[7] Board of Healthcare Funders of Southern Africa, Prescribed Minimum Benefits, available at: http://www.bhfglobal.com/prescribed-minimum-benefits

[8] Council for Medical Schemes (2000) Prescribed Minimum Benefits: 10 Things your members need to know about PMBs, available at: http://www.medicalschemes.com/medical_schemes_pmb/PMBs%20MedSchemes.pdf

[9] Board of Healthcare Funders of Southern Africa, Prescribed Minimum Benefits, available at: http://www.bhfglobal.com/prescribed-minimum-benefits

from devising schemes to suit particular categories of members and circumstances, and, especially important, when establishing schemes that cater for low-income people, to limit costs.

PMBs act as a *de facto* entry barrier because they prevent actuaries from designing low-income insurance packages. When benefits are determined politically, rather than by what individuals want, the benefit package and the costs required to cover them expand. The consequence is that low cost medical schemes that cover the specific basic needs of low-income people cannot be designed accordingly. To increase the number of beneficiaries covered and to reduce the cost of medical scheme options, government needs to remove PMBs. Alternatively, it could allow certain schemes at the low end of the market to be exempted from PMBs to allow actuaries to devise options that cater for low income individuals.

Statutory solvency requirements

The SA government introduced statutory solvency ratios for medical schemes in the Medical Schemes Act of 1998. Statutory solvency ratios are used to indicate the financial health of medical schemes. Regulation 29 of the Act prescribes that the minimum accumulated funds of the medical schemes should be at least 25 per cent of gross annual contributions.[10] The Council for Medical Schemes (CMS) notes, "These 'minimum accumulated funds' are more commonly referred to as the 'reserves' of a scheme". When expressed as a percentage of gross contributions, this is known as the 'solvency ratio' of a scheme. The solvency level of a medical scheme is defined as the accumulated funds (excluding the revaluation reserve) divided by gross annual contributions in respect of a particular accounting period".[11]

This legislation was enacted to prevent a scheme from going insolvent should it experience an unusually high number of claims and record an operating loss in a particular period. But the formula for calculating the current solvency ratio was arbitrarily decided with no regard to the implications for the functioning of medical schemes. The solvency requirements were set at a level of 10 per cent when they were introduced in 2000, and have since been increased by incremental amounts to the current level of 25 per cent, which has been effective since 2004.

According to the Actuarial Society of South Africa, solvency is an asymptotic function of contribution increase. In other words, the higher the solvency requirement, the greater the increase required to improve solvency by 1 per cent. For example, increasing the solvency requirement from 10 per cent to 11 per cent requires a contribution increase of 1.39 per cent. However, increasing the solvency requirement from 24 per cent to 25 per cent requires an increase of 2.07 per cent in contributions. Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.

A scheme that has reserves below the legislated 25 per cent minimum requirement will have trouble 'catching up' because new members will be in the invidious position of having to contribute not only towards their own portion of the required reserves, but also towards making up past shortfalls, a cost for which they will receive no benefit. Despite the intentions of the SA government to prevent schemes from failing, the solvency requirements will increase contributions, which, in turn, will adversely affect the number of individuals covered by schemes. Under the community rating system, schemes need to attract new young members constantly in order to cross-subsidise the older

[10] *Ibid*

[11] Council for Medical Schemes (2008) Council for Medical Schemes Annual Report, available at: http://www.medicalschemes.com/publications/ZipPublications/Annual%20Reports/Annual_Report_2007-8.pdf

members in the scheme. If this is not done, the average age in the pool will increase and the average premium will have to rise commensurately. The solvency ratios of schemes that are growing are placed under pressure because if a scheme's membership increases rapidly, its contribution income has to rise steeply.

As noted previously, a scheme's solvency ratio is determined from the reserves as a percentage of the contributions. If the contributions increase without a similar increase in the reserves, the solvency ratio will decrease. Solvency requirements are a barrier to entry for new medical schemes trying to enter the private medical schemes market. It is unreasonable to expect potential entrants to raise enough capital, not only to fund their daily activities, but also to meet the statutory solvency requirements. Considering South Africa's aging population and the barriers to entry in the market, we could reasonably expect to see substantial consolidation of existing medical schemes.

The statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme that has accumulated reserves that exceed the required minimum is in a better position to attract new members than one that has a shortfall. It will be particularly difficult for new medical schemes to enter the market and rapidly growing schemes will be at a disadvantage relative to slowly growing ones. This is not a desirable situation given the substantial expected future demand for health care in the country.

The SoI states,

> *"34. In addition, the Panel will inquire into the role and impact on competition and sustainability of the sector of health insurance products of financial service providers that are not medical schemes and are not subject to the rules for medical schemes set out above".*

Gap and other healthcare cover options provided by insurance companies are simply creative ideas developed by these companies to address a need created by the Medical Schemes Act of 1998 described previously. Recognising an opportunity to provide insurance based products like gap cover private medical insurance companies are effectively attempting to fulfil a desire of consumers in the market that has come about due to the bad laws created by government. Gap insurance has arisen directly as a result of the restrictions imposed on medical scheme actuaries from devising products to suit individuals' needs. Indeed, if medical scheme actuaries were free to design products that suited individual needs, it is likely that none of these products would have appeared in the first place.

Providers of healthcare products and services

> *36. The private hospital sector consists of three large hospital groups, in addition to an association of independent hospitals and some independent hospitals not affiliated to the association. The Panel wishes to understand the impact, if any, of hospital concentration and possible market power at national, regional and local levels. In particular: are there features that harm competition among private hospitals; does market power arise from possible unilateral conduct and/or coordination of private hospitals; what is the impact of possible market power on bargaining between hospitals and medical schemes/administrators; and what is the impact of possible market power on costs? Further, the inquiry seeks to understand how hospitals compete with regard to investment in technology and attracting practitioners to their respective hospitals, the regulatory requirements affecting entry and expansion, and the implications of these for competitive outcomes.*

Stringent licensing requirements need to be met before anyone can establish or even expand an existing hospital. Strict rules and regulations determine the minimum size of each room in the hospital,

from the reception room to the operating theatres, changing rooms and wards. These regulations restrict competition and prevent smaller or new competitors from entering the market and encourage consolidation when there is a need to expand.

Unnecessary limitations on entry into the hospital and clinic market, and the purchase of expensive technical equipment, decrease competition and will tend to drive up prices. Certificates of need are mechanisms that are designed to limit competition. A fully competitive market does not have such barriers to entry, especially barriers that are dependent on the discretionary decisions of officials. Concerns about safety can be dealt with by establishing objective and clear requirements that if met, allow participants to proceed with investments without prior approval. If investors commit errors of judgement, they do so at their own cost.

> *38. The sector consists of a number of different kinds of practitioners offering a variety of services and specialising in different disciplines. If the inquiry is to be focused and manageable, it will be necessary to identify criteria for identifying which types of practitioners to prioritise and which disciplines to focus on for further evaluation. At the outset, the Panel wishes to identify general practitioners (GPs) as a priority because of their important gatekeeper role in directing patients through the healthcare pathway. With respect to specialists, however, the Panel may identify areas of focus based on factors like contribution to overall costs, the rate of cost increases and frequency of use. The Panel invites submissions on appropriate prioritisation criteria and welcomes any proposals on what the focus areas should be.*

The FMF considers government planning and prioritisation extremely problematic. These issues are captured well in the following quote by Johan Biermann a healthcare consultant:

"Proponents of government health systems argue that such systems ensure the optimal and productive utilisation of the country's health-care resources. Their arguments are based on the fallacy that there is someone who actually knows how to allocate health-care resources in an equitable manner and what optimal health resources would comprise. However, as explained by Nobel laureate Friedrich Hayek, such a person or organisation cannot exist. Hayek's writings teach us that government planning cannot achieve the efficiency in the use of resources which market processes make possible because the knowledge required to do so is dispersed among thousands and millions of individuals. All government enterprises and state-controlled companies fall prey to what has become known as "the knowledge problem" and South Africa is no exception".

Biermann gives an example:
"When an application for a certificate of need is received the health planners in the offices of the Director-General of Health are faced with an impossible task. To properly process an application the health planners have to be all but omniscient, an impossible expectation. They need to know the health needs of everybody in a given geographical area: the number likely to fall ill, the type of illnesses likely to befall them, the existing number of facilities, beds, and equipment, the rates of utilisation of services and facilities, how effective the doctors are, the effectiveness of treatments and medicines, and so on. The equation becomes even more complicated when one considers that people do not necessarily use the health services located closest to them. How does the health planner then determine the trading area for a particular facility?"

The evaluation procedure that is being considered in 38 suffers from the same problems described above that assail the government planner. How will the evaluators separate out the real source of costs involved in the whole panoply of health services? And once they have collected what they believe to be the source of the costs, will they proceed to try and dismantle a process that has come about because of factors that they cannot possibly properly understand. What role is played by the

fact that hospitals are not allowed to employ doctors and specialists? What role is played by the artificially created shortage that results from a refusal to allow the private sector to train doctors?

> *39. With regard to GPs and specialists, the Panel seeks to understand how they make decisions on directing patients through the healthcare pathway; the impact of scarcity of specialist skills on competitive rivalry; the impact of the rules and requirements of the Health Professions Counsel of South Africa ("HPCSA") on competition; and the impact of any skewed distribution of practitioners in different areas.*
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> *41. The Panel wishes to understand the relationship between practitioners and hospitals. Practitioners operate out of hospitals, but HPCSA rules prevent practitioners from being employed by hospitals. However, practitioners may own shares in hospitals. The Panel wishes to understand the rationale and the implications of these rules for the incentives and actions of practitioners, the relationship between hospitals and practitioners, and whether these incentives and actions are harmful to costs, prices and quality of treatment provided and to competition.*

In terms of the ethical rules of the Health Professions Council of South Africa (HPCSA), private hospitals are prevented from appointing doctors and other health professionals, with the exception of nursing staff. Since private hospitals cannot appoint doctors directly, they offer incentives to attract healthcare professionals to establish various practices within hospital premises. These incentives may cause the price of services to rise. Moreover, since government holds a monopoly on the training of doctors in this country, the available supply is severely and artificially restricted, which raises the price that doctors and specialists can charge. Doctors and specialists should be allowed to work wherever they choose without restriction or being tied to the public sector and the private sector should be allowed to train doctors, which would not only increase the available supply to the private sector but also the public sector.

In terms of rules created by the HPCSA, South Africa is the only country in the world where private hospitals are prevented from directly employing doctors. Private hospitals thus resort to other methods in order to attract various healthcare professionals to establish their practices within private hospital premises. For example, they may invest in sophisticated equipment and/or improve the infrastructure to make the hospital more appealing. This has the effect of driving up prices which are ultimately passed on to the patient. These rules should be amended so that doctors and other medical specialists can be employed directly by private hospitals.

> *43. The consumables market includes pharmaceutical products and other medical consumables. Pharmaceuticals form a considerable part of consumables and operate within a highly regulated market through the Single Exit Pricing (SEP) regime, and are affected by efforts to facilitate generic competition. The Pharmacy Council of South Africa oversees ethical conduct by pharmacists. The other noteworthy part of the consumables market includes the market for medical technology and devices. The Panel wishes to understand the impact of consumables on costs and competition in private healthcare.*

Pharmaceutical manufacturers have generally been forced to endure a below-inflation increase since the introduction of the Single Exit Price (SEP) mechanism. In 2004, the government introduced the SEP mechanism which is applied to all medicines supplied to the private healthcare sector. SEP compels all manufacturers and importers to sell their products at the same price to all of their private sector customers, regardless of the size of the order, and prohibits them from offering any discounts. Not subject to the SEP constraints is the Department of Health which has a pricing committee that, by using a formula, recommends what the annual increase for the private sector should be. In 2014 the

pharmaceutical industry was permitted to raise prices by a mere 5.82 per cent as announced by the Minister of Health. However, the Department of Health's own pricing committee recommended an increase of almost 9 per cent (headline CPI for 2013 averaged 5.7%) but the Minister of Health used his discretionary powers to arrive at a much lower figure and stipulated that 5.82 per cent was the allowed maximum annual price increase.

As indicated, the SEP applies to the private sector only. No pharmaceutical company may donate medicine to the private sector or sell medicine to a private company at a reduced price. Government, though, has a much greater freedom. State tender prices reveal that some medicines are available to the state at about one-tenth of the cost to the private sector. For example, since 2002, Novartis has been providing its cancer drug Glivec (branded as Gleevec in SA) to uninsured public sector patients via the Glivec International Patient Assist Program (GIPAP) to such an extent that approximately 63 per cent of Gleevec used currently in SA is being provided at no cost at all.

Nobel Prize winning economist Friedrich Hayek said, "*The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design".* Price controls seem to be a favourite policy intervention by legislators because they assume that, by a simple stroke of the statutory pen, access to the commodity in question will increase. They are mistaken because the market is far more complex and the price mechanism, which plays an intricate role in sending signals to producers and consumers, cannot be overruled.

Government controlled prices require a protracted research and consideration period, and, once set, cannot be quickly or spontaneously adjusted to meet changing market circumstances. Price controls distort the pricing mechanism and interrupt the dynamic demand and supply process. The application of long discredited economic policies such as price fixing and giving the Minister of Health the discretionary power to determine prices increasingly frustrates competition and restricts access to medicines. Competition is the only and surest path to lower prices, whatever the product.

Moreover, the government continues to levy VAT on pharmaceutical products sold in the private sector. According to the World Health Organisation, "Countries at all income levels raise taxes from the sales of medicine. Yet some countries, including low-income countries, specifically exempt medicines from all taxes. The price-responsiveness of demand for medicines has been measured in several settings and shown to be positive but less than one, meaning that an increase in price, other things being equal, will reduce demand and vice-versa. Some groups of people – the poor and the elderly – are more sensitive to price changes than others".[12] VAT is a regressive tax, which means that it is "inequitable", since the amount paid on a certain product is a percentage of its price, and is the same for rich and poor people. In other words, the tax burden for a given product forms a larger share of a poor person's income than of a rich person.

The South African government has already recognised the importance of exempting certain basic foodstuffs from VAT and have introduced a zero-rated VAT status as a consequence. Indeed, Bird (2005) states, "…many (developing and transitional economies) provide reduced VAT rates or exemptions for certain "basic" items such as some foods, passenger transport, medical services, and cooking fuel".[13] Thus, some leading international tax policy advisers recognise the importance of exemptions – such as for medical care – from tax schedules.

[12] WHO/HAI (2011) WHO/HAI Project on Medicine Prices and Availability. Review Series on Pharmaceutical Pricing Policies and Interventions. Working Paper 5: Sales Taxes on Medicines.

[13] Bird RM. Value-added taxes in developing and transitional countries: lessons and questions. International Tax Program Paper 0505, Rotman School of Management, University of Toronto, 2005. Accessed at http://www.rotman.utoronto.ca/iib/ITP0505.pdf.

Charging VAT on medicines in general and particularly essential medicines, is counterintuitive. If government wants a healthy and productive workforce it should not impose this tax on the sickest and most vulnerable members of society. Taxes on medicines are highly regressive and severely penalise the poorest and most vulnerable members of society. In a democratic state, removing them should be both politically popular and feasible. Eliminating taxes that keep essential medicines out of the hands of the poorest of the poor should therefore be a priority for the South African government.

The role of the public healthcare sector

> *45. The Terms of Reference exclude the public sector as a focus area of this inquiry. However, the Panel considers it important to understand how the public and private healthcare sectors interact and what, if any, constraints exist between the two that affect competitive outcomes in the private health sector. For example, there may be areas of excellence in the public healthcare sector, like academic hospitals, which may pose some competitive constraint on private hospitals. The Panel wishes to understand the extent of this.*

> *46. The Panel welcomes any submissions that stakeholders may wish to make in this regard, but wishes to stress that these should be related to issues that have a bearing on outcomes, competition, costs, prices, and expenditure in the private health sector rather than issues pertaining to outcomes in the public sector.*

In order to improve competition in private health care, government should remove all the restrictions, barriers to entry, and government-created delays that hamper the providers of private health care and reduce competition. This would allow South Africans to enjoy the best medical care that a freely competing private health care industry is capable of producing.