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The Competition Commission
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Dear Sir / Madam

SOUTH AFRICAN DENTAL ASSOCIATION - COMMENTS ON DRAFT TERMS OF REFERENCE FOR MARKET INQUIRY: PRIVATE HEALTHCARE SECTOR

1 INTRODUCTION

1.1 We refer to the document issued by the Competition Commission (“Commission”) entitled “Draft Terms of Reference for Market Inquiry: Private Healthcare Sector” (“Draft TOR”) and to the “Call for Public Comment” on the Draft TOR issued by the Commission (“Call for Comment”).
1.2 The South African Dental Association ("SADA") accepts the Commission’s invitation extended in the Call for Comment to provide comments on the Draft TOR. In this regard, we submit our views and comments thereon below.

1.3 Please note that SADA’s comments contained in this document should not be construed or interpreted as a waiver or admission or act as an estoppel against SADA in any manner whatsoever. SADA’s comments should, therefore, not be regarded or interpreted as, amongst other things, acquiescence to the process or policy adopted or pursued by the Commission in terms of the market inquiry envisaged in the Draft TOR or any other document.

2 BACKGROUND TO SADA

SADA is a national professional body representing the majority of registered dental practitioners engaged in clinical practice both in the private and public healthcare sectors in South Africa. These dental practitioners comprise of dentists and dental specialists who are employed in both the private and public sectors. Members also include dental students registered at dental schools and those performing compulsory community services.

3 COMMENTS ON CERTAIN PROVISIONS OF THE DRAFT TOR

3.1 We understand from the note on page 3 of the Draft TOR that the Draft TOR is intended for the purposes of conducting consultations with stakeholders. As such, we understand that the contents of the Draft TOR will change and we have, therefore, set out below our in principle comments on the Draft TOR.

3.2 Comments on “1. Introduction”

3.2.1 The term “private healthcare market” is defined in paragraph 2.1 of the Draft TOR (“Structure of the Private Healthcare Market”) as follows:
“The private healthcare market refers to that portion of healthcare services that are paid for by private patients themselves, either through medical scheme (insurance) payments or through out-of-pocket payments.”

3.2.2 This description assumes that so-called “private patients” do not utilise public hospitals or healthcare. To our knowledge, a person who is a member of a medical aid is not prevented or disqualified from receiving treatment in a public hospital.

3.2.3 In addition, dental practitioners do not only treat “private patients”. As stated above, SADA members comprise of dental practitioners who participate in the “private healthcare market” and the public healthcare sector. Dental practitioners are qualified to work in the private and/or public healthcare sectors and the private sector presently serves a substantial part of the uninsured population in South Africa.

3.2.4 We point out that the Explanatory Note to the General Regulations published in terms of the Medical Schemes Act, No. 131 of 1998, states that the objective of specifying a set of “Prescribed Minimum Benefits” is to:

(i) “avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals”; and

(ii) “to encourage improved efficiency in the allocation of Private and Public health care resources”.

3.2.5 Accordingly, the abovementioned regulations recognise that resources and utilisation considerations in private healthcare affect public healthcare and vice versa.
3.2.6 In our view, therefore, the proposed market inquiry should not only focus on the “private healthcare market” without proper consideration and due regard to the public healthcare sector. It is submitted that a proper analysis of the public healthcare sector would include an assessment envisaged in paragraphs 3.2 and 3.3 of the Draft TOR, read with the necessary changes.

3.3 Comments on "2. Overview of the private healthcare market"

3.3.1 The Draft TOR states that the market inquiry will include a “broader review of the regulatory framework wherein healthcare players operate”. As stated in paragraph 2 above, dental practitioners participate in both the private and public healthcare sectors and, therefore, the regulatory framework applicable to the private and public healthcare sectors should be reviewed by the Commission. The healthcare sector is a highly regulated sector and involves certain complex arrangements and relationships involving patients, providers and/or funders.

3.3.2 In this regard, the dental profession is regulated by, amongst other things, the following:

3.3.2.1 the Dental Technicians Act, No. 19 of 1979;

3.3.2.2 the Medical Schemes Act, No. 131 of 1998, as amended;

3.3.2.3 the National Health Act, No. 61 of 2003;

3.3.2.4 the Health Professions Act, No. 56 of 1974, as amended;

3.3.2.5 the ethical rules of conduct and rulings issued by the Health Professions Council of South Africa ("HPCSA") which bind dental practitioners who provide dental services to members of the public; and
3.3.2.6 The Consumer Protection Act, No. 68 of 2008.

3.3.3 The regulatory environment in the healthcare sector is dynamic, with many regulatory issues often arising at the same time. By way of example, we point out that there are presently draft proposals on the National Health Insurance ("NHI") scheme which have been issued by the Department of Health and currently the HPCSA is purporting to determine ‘guideline tariffs’. In this regard, the HPCSA has invited comments on the process to be used for the determination of ‘guideline tariffs’.

3.3.4 In the circumstances, it is submitted that it would be relevant and necessary for the Commission to consider and take into account the nature and scope of all relevant legislation, tariff determination processes, ethical rules and rulings as part of the market inquiry process, particularly if the Commission intends making definitive findings and “evidence-based recommendations” in this dynamic and highly regulated environment.

3.4 Comments on “2.1.1. Healthcare services”

3.4.1 Payments to dental practitioners by medical schemes in the year 2000 accounted for approximately 4% of the total medical scheme payments to service providers; it is now (2012) only approximately 2% of the total payments made to dental practitioners by medical schemes. As such, payments by medical schemes to dental practitioners have decreased over time and account for a very small portion of the total healthcare expenditure.

3.4.2 The Commission states in the second paragraph on page 5 of the Draft TOR that “there is still a perception that providers differentiate between
patients; particularly between patients that have medical aid and those that do not”. The Commission does not, however, indicate who holds this perception (whether it is the Commission or other parties) and how this perception, if at all, affects interactions between providers and patients. The Draft TOR does not explain how this perception is relevant to the “evaluation of costs and expenditure in the healthcare markets”.

3.4.3 We point out that there is ample evidence from international literature and from South African analyses that identify important factors contributing to healthcare expenditure including, amongst other things, burden of disease (people are generally sicker or have more than one illness), better diagnostic techniques, salary inflation, an ageing population, community rating and open enrolment of medical schemes, and expensive technology used in new or better procedures. In the circumstances, we submit that the Commission should perform a comprehensive systemic analysis, taking all of the relevant factors into account, when evaluating costs, expenditures and interdependencies in the healthcare sector, before forming any conclusions as to the cause for the “upward pressure on healthcare expenditure”. In this regard, we note that the Commission has indicated in paragraph 3.2 on page 11 of the Draft TOR that it intends to, amongst other things, evaluate the “nature of price determination...” with reference to “...the level and structure of prices of key services, including an assessment of profitability and costs”.

3.4.4 The Draft TOR goes on to state that healthcare providers’ prices are not regulated. Although this may be the case, we point out that medical schemes (and as a consequence, medical scheme members) place pressure on healthcare providers to charge at the so-called “medical aid
rates” of the medical schemes in question. In addition to these constraints, healthcare providers who form part of a designated service provider network (or a managed care arrangement referred to in paragraph 2.1.3 of the Draft TOR) typically provide care to patients at a reduced charge. The use of generic medicine is one of the ways in which patients can proactively minimise the cost of healthcare. Accordingly, there are a number of constraints on healthcare providers’ prices.

3.5 **Comments on “2.1.2 Hospitals”**

3.5.1 The Commission does not give the source for the assertion that hospitals account for 36% of the total private healthcare expenditure. In addition, it is not clear to us who the “corporate group” being referred to is.

3.5.2 We point out that there are a number of studies which have considered the underlying causes of increases in hospital prices. Certain of these studies hold divergent views as to the cause of increases in hospital prices and therefore, it is paramount for the Commission to appreciate the causes for such price increases before recommending an appropriate intervention.

3.5.3 As stated above, there are many factors which could influence price increases, including the worsening disease burden\(^1\) in society in general and the possible consequence of regulatory amendments made to the medical schemes environment since 2000 which have encouraged young, healthy or low-risk individuals to opt out of medical schemes in response to the increased medical scheme premiums they faced.

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\(^1\) See the Department of Health’s Annual Report 2011 – 2012, pages 61 to 67.
3.6 Comments on “2.1.3. Financing, administration and managed care services”

3.6.1 The Commission does not explain the basis for its statement that managed care arrangements “have not been widely used in South Africa”. As the basis for that conclusion is unclear, we submit that it would be prudent for the Commission to first independently assess whether, in fact, managed care arrangements are widely used as opposed to accepting this statement and trying to find the reasons therefor.

3.6.2 It is our observation that in certain instances managed healthcare organisations appear to independently determine the capitated fee payable by a medical scheme to a managed healthcare organisation. Accordingly, when it comes to determining the benefits to that medical scheme’s members, managed care organisations are in a position to dictate to the medical scheme what should or should not be charged with reference to the capitated fee or risk portion of the fee that has been agreed between the managed care organisation and the medical scheme.

3.7 Comments on “2.1.4 Consumables”

In dentistry, consumables (other than pharmaceuticals) are one of the input costs of providing dental services to patients. These dentistry consumables are, to our knowledge, not price regulated and are subject to price adjustments by the producers and suppliers thereof. Our understanding is that these dentistry consumables are extremely sensitive to the exchange rate and fluctuations thereto. Accordingly, the Commission would need to take such consumables and dental equipment (together with all of the factors which influence the prices thereof) into account when assessing the reasons for price increases in the healthcare sector.
3.8 **Comments on “2.2 History of the regulatory and policy changes in the healthcare sector”**

3.8.1 We have assumed that the reference to the year 1993 (in the first unnumbered paragraph on page 7 of the Draft TOR) is important only because it was the year in which the Medical Schemes Act was amended (as referred in the third unnumbered paragraph on page 7 of the Draft TOR). In this regard the Commission does not, however, explain to which amendments or “[changes to the Medical Schemes Act in 1993]” reference is being made.

3.8.2 In the second sentence of the first unnumbered paragraph on page 7 of the Draft TOR, the Commission refers to regulations which, amongst other things, specified “tariffs that could be charged by healthcare providers and reimbursement rates for medical aid schemes”. It is, however, not clear to us how tariffs particularly applicable to medical scheme patients could have generally determined the viability or costs in private healthcare.

3.8.3 We point out that the National Health Act, No. 61 of 2003 (“**NHA**”) was not in existence before 1993 and it, therefore, had no bearing whatsoever on healthcare regulation at that time. We point out further that the private healthcare industry was “not regulated by government” only through the NHA and the “Medical Schemes Act of 1967” before 1993, but by all of the healthcare legislation in effect at that time, including the legislation referred to in paragraphs 3.3.2.1 and 3.3.2.4 above. For the aforementioned reasons, the statement in the first unnumbered paragraph on page 7 of the Draft TOR is inaccurate and the purported “history of regulatory … changes in the healthcare sector” appears to be a very narrow overview.
As a matter of logic, it does not follow that “balance billing” resulted in “increased expenditure on private healthcare” (which is referred to on page 8 of the Draft TOR). As stated in the Draft TOR, “balance billing” arises where the charge for providing the healthcare treatment or service in question exceeds the medical aid rates (of the medical scheme in question) for reimbursement therefor. Such medical aid rates are determined by medical schemes and such rates (and benefits) may not have kept pace with the costs of providing the healthcare treatment or service in question.

3.9 Comments on “3. The Proposed Market Inquiry”

3.9.1 It is submitted that the “functioning of these relationships, and the nature of the incentives faced by providers and payers in the medical value chain” are not the only factors which “determine the eventual price, quality and innovation outcomes that patients experience”. In our view, factors such as the legislative framework, ethical rules, clinical best practice, input costs and competition in the relevant markets are amongst the relevant considerations in this regard.

3.9.2 The Commission does not indicate the source of or explain the statement that there are “various concerns” around “the functioning of private healthcare markets in South Africa because healthcare expenditure and prices across key segments seem to be rising notably above headline inflation”. In addition, no explanation is provided for stating that there are “distorted incentives inherent in healthcare markets”. In view of these statements, it is submitted that the Commission should independently and objectively assess the healthcare sector in order to make evidence based conclusions, by scrutinising market commentators or third parties’ views on the state of the healthcare sector.
3.9.3 Whilst we appreciate that the process of conducting the market inquiry requires the engagement of stakeholders, and consideration of credible data, research and collaboration, it is not clear how the Commission intends to co-ordinate or reconcile the market inquiry with the process already underway by the HPCSA, which is ostensibly investigating processes for the determination of ‘guideline tariffs’ for doctors and dental practitioners, and the preparation and publication of the NHI White Paper. We point out that we do not express a view on whether the HPCSA is lawfully entitled to determine ‘guideline tariffs’ for doctors and dental practitioners.

3.9.4 Furthermore, we note that the Draft TOR does not make mention of or seem to take cognisance of the effect which the public sector and certain government initiatives (such as the NHI) will have on the private healthcare sector.

3.10 Comments on "3.1 Rationale for a Market Inquiry"

3.10.1 We submit that any conclusions drawn or action taken by the Commission regarding private healthcare should be “evidence-based”. This is particularly relevant as the NHI Green Paper tends to drift in the direction of either blaming the private sector for inequalities between private healthcare and public healthcare for many of the problems with the South African health system. The Commission should be mindful of accepting as fact views which “blame the failings” of the public sector on the perceived “failings” of the private healthcare sector.

3.10.2 Whilst we note the Commission’s reference to the Constitution, it is not clear how the Commission relates section 23(2) of the Constitution to the rationale for the Commission’s market inquiry. Furthermore, the
Commission states that its market inquiry will “probe various segments” of the private healthcare market and that such segments were selected on the basis of the “Commission’s preliminary research”. No further information or description of that “preliminary research” is provided. We, therefore, cannot comment on the manner in which the “Commission’s preliminary research” was conducted and if, for example, we agree with the conclusions contained in that “preliminary research” or whether it constitutes a suitable, rational and reasonable basis on which to launch a market inquiry at all.

3.11 Comments on “3.2. Purpose and Objectives”

3.11.1 We note that the Commission acknowledges in the first paragraph of the paragraph entitled “1. Introduction” that the market inquiry will be conducted “in keeping with the purpose and functions of the Commission set out in the Act”. However, on page 11 of the Draft TOR, the Commission states that certain of the objectives of the market inquiry are for the Commission to evaluate the nature of price determinations in the private healthcare market (with reference to, amongst other things, profitability and costs) and to make recommendations on whether price-setting mechanisms may be acceptable within the competition policy context. In this regard, we point out that:

3.11.1.1 the Competition Tribunal indicated in the decision of Harmony Gold Mining Company Limited and another vs Mittal Steel South Africa Limited and another (Competition Tribunal case number 13/CR/Feb04) that it eschewed the role of a price regulator. The Competition Appeal Court held at paragraph 47 in the decision of Mittal Steel South Africa Limited and two others vs Harmony Gold Mining Company Limited and another
(Competition Appeal Court case number 70/CAC/Apr07) that the powers and duties of the competition authorities, and their limitation, are contained in the Competition Act, No. 89 of 1998 ("Competition Act"). The Competition Appeal Court went on to state that there was no suggestion in the Competition Act that the competition authorities should regulate and set prices, unless this was required by virtue of an express formulation of the Competition Act;

3.11.1.2 as stated in paragraph 3.9.3 above, bodies such as the HPCSA are already in the process of determining tariffs.

3.11.2 It is our understanding that the Commission’s market inquiry is directed at achieving the purpose of the Competition Act, namely to promote and maintain competition in the Republic, and/or to assess competition within a particular market. As such, it is submitted that the Commission is not empowered or charged with determining prices or tariffs in the healthcare sector and it should not use the market inquiry to do so. As stated in paragraph 3.2 above, we submit that such a market inquiry would need to give proper consideration to and have due regard to the effect of the public healthcare sector on the private healthcare sector.

3.12 Comments on “3.3 Subject Matter of the Inquiry”

It is noted that the market inquiry will be focusing on private healthcare providers, hospitals, medical aid schemes, medical aid administrators and medical aid brokers. Given the broad range of issues which the market inquiry will consider, we submit that the Commission should be equipped with the relevant industry experts and professionals in order to fully consider the complexities and regulatory framework of the healthcare sector.
3.13 **Comments on “3.3.1 Healthcare providers (Primary Care and Specialists)”**

To ensure a holistic consideration and assessment of the healthcare sector, as stated above, we submit that it is important for the Commission to consider, amongst other things, the ethical rules of conduct for dental practitioners registered with the HPCSA, the effect of those rules on dental practitioners and would need to give proper consideration to and have due regard to the effect of the public healthcare sector on the private healthcare sector as indicated in paragraph 3.2.6 above.

3.14 **Comments on “3.3.3 Medical Schemes, Administrators, Brokers and Managed Care”**

Non-health expenditure is one of the costs of conducting the business of a medical scheme. We understand that non-health expenditure of medical schemes increased by 4.8% from R11.6 billion to R12.1 billion in 2011. It is, therefore, apposite for the Commission to assess (as it has indicated that it would) how fees, including contributions and administration fees, are determined.

3.15 **Comments on “3.4 Methodology”**

3.15.1 It is submitted that the Draft TOR lacks detail and refinement of the practice and procedures the Commission intends to follow in relation to the implementation of the proposed market inquiry. In this regard, we refer to our comments at paragraph 3.17 and 3.19 below.

3.15.2 The reference to “secondary material” is vague and unclear. The Draft TOR should provide more information on who the ‘experts’ are that will sit on the panel and should also set out their qualifications and expertise.
Furthermore, it is not clear whether the panel of three experts and their support team are the same personnel referred to in paragraph 3.6.4 of the Draft TOR.

3.16 Comments on “3.5 Stakeholders”

The HPCSA regulates the behaviour and conduct of practitioners in the private and public healthcare sectors by means of ethical rules, rulings and its intended ‘guideline tariffs’. Accordingly, we are of the view that the HPCSA’s participation is crucial, including the participation of other relevant stakeholders from the public healthcare sector.

3.17 Comments on “3.6 Proposed Market Inquiry Process”

It is clear from the contents of this paragraph that the phases of the market inquiry are merely indicative and are likely to go through a number of iterations of improvements and refinement before being finalised. In our view, in order for public participation and consultation to be effective and of assistance to the Commission, interested parties should be afforded the opportunity of commenting on the finalised provisions relating to the “phases of the inquiry”. It is, however, not clear from the Draft TOR whether the Commission will furnish interested parties with an opportunity of commenting on the final iteration of the phases of the market inquiry before it is published in the Government Gazette.

3.18 Comments on “3.6.1. Launch”

We note that the Commission intends discussing the Draft TOR with the stakeholder groupings identified in paragraph 3.5 of the Draft TOR. As an industry association which represents the interests of a large number of dental
practitioners, we confirm that we are amenable to discussing same with the Commission.

3.19 Comments on “3.6.3 Estimated Timelines of the Market Inquiry”

3.19.1 The Draft TOR are broadly formulated and lack specificity regarding the detailed procedure and timelines that will be followed and the manner in which the inquiry will be implemented. For instance, there are no clearly defined milestones of pertinent events leading up to and during the market inquiry. It is submitted that such detail would create certainty to the process and allow parties to constructively comment on such milestones and process. The danger of not having clearly defined terms of reference, including a clear process of how those terms will be implemented, is a substantial increase in the management time and cost of providing information and documents to the Commission, dealing with queries from the Commission and making individuals available for interrogation by the Commission. This may be illustrated with reference to the banking inquiry:

3.19.1.1 The banking inquiry, which was conducted on a voluntary basis, demonstrated that market inquiries can be time-consuming and expensive for all parties involved. The terms of reference for the banking inquiry were released in August 2006, and it went on for two years, ostensibly costing the banks millions in legal and consultants’ fees, and management time.

3.19.1.2 Furthermore, twenty-one days of hearings were spread over four months and participants had to respond to numerous requests for submissions and meetings with the Commission. The terms of reference had called for a final report to be delivered by the chair of
the inquiry to the commissioner within one year, but the report was delayed by almost a year, and was only released by the Commission to the public a further six months later, in December 2008.

3.19.2 We submit that it would be in the best interests of all relevant parties, including the Commission, to ensure that the terms of reference of the market inquiry are clear and sufficiently detailed as to the methodology and timeframe within which certain events will occur.

3.20 Comments on "3.6.4 Human Resources"

We cannot comment on the composition of the panel as such panel has not been appointed yet. As stated above, given the complex and highly regulated nature of the healthcare sector, it is important that suitably qualified and experienced individuals are appointed to the panel.

4 CONCLUSION

4.1 A wide and undefined market inquiry will be difficult to effectively marshal in a way that will lead to a clear, timely and effective outcome. Certain commissions of enquiry are derailed due to a lack of clear terms of reference.

4.2 The Commission should approach the market inquiry without prejudging any of the issues and with a view to fulfilling its mandate in terms of the Competition Act, whilst being mindful of the rights in the Bill of Rights in the Constitution, including but not limited to, the right to procedurally fair administrative action. Price regulation, even if indirect, can distort provider responses to consumer demand and restrict consumer access to health care services which will bring the result of the market inquiry into conflict with section 27 of the Constitution and possibly expose the entire process to legal review.
4.3 We trust that our comments on the Draft TOR have been of assistance to the Commission.

Yours faithfully

Maretha Smit
CEO