KEYNOTE SPEECH FOR THE MINISTER OF HEALTH, DR. A MOTSOALEDI, MP AT THE 6TH ANNUAL CONFERENCE ON COMPETITION LAW, 6TH TO 7TH SEPTEMBER, WITS UNIVERSITY

Programme Director

The Competition Commissioner, Mr Shan Ramburuth

Local and International Delegates

Distinguished Guests

Ladies and Gentlemen

A very good morning to you all.

It is with great pleasure that I accepted the opportunity to address the 6th Annual Conference on Competition Law. I also accepted this invitation with great humility because I am supposed to be giving a keynote address on matters of Competition Law, and as you know, it is not my domain at all.

However, as Minister of Health, my domain is in understanding what type of health system does a country need. A healthcare system must have three main attributes. Firstly, it must be accessible to all the citizens and by all I mean all, the rich, the poor, the young, the old, the sick, the relatively healthy, the employed, the unemployed, the mighty and powerful, as well as the marginalised. Secondly, it must be of good acceptable quality. And thirdly, it must be affordable.

If competition matters are a hindrance to any of these three attributes, then that becomes my domain too.

My very first international engagement as a Minister of Health, was to attend a meeting at the United Nations, that was in June 2009. We were summoned by the Secretary General of the United Nations (UN), Mr Ban Kin Moon, and the Director General of the World Health Organisation (WHO), Dr Margaret Chan. Their main reason for summoning us, was that they were worried that in the face of global economic meltdown, many countries will be tempted to reduce social services, especially health. Their message was crystal clear, and it was that despite the deepening financial crisis leading to austerity, the fair thing to do is to protect people's health and not reduce the services.

The over-arching drive that pushed these two eminent persons to raise their concern and send an ambiguous message, is their conviction that health is a public good, and not just any other commodity that must be left to the whims of the so-called market forces.

I want to declare straight away, that this is the conviction that I share unreservedly and it is the driving force behind what I am going to say today.

Perhaps I should start by telling you who I am, and not assume that you know all about me. I am the Minister of Health, I am not the Minister of Public Health only, but I am the Minister of both public and private health. I am not the Minister of hospitals and clinics, but of Health. I wish to remind you that health does have a specific definition, which is contained in the declaration of Alma Ata, as declared by the WHO in 1978, and I quote: *"health is not just the absence of disease or infirmity, but it is the state of good physical, social and mental wellbeing, and that the attainment of the highest standard of health is the most important worldwide social goal whose realisation need action from other sectors, economic and social in addition to the health sector".*

This declaration ended with the slogan: "Health for All by the year 2000".

We do know that this dream of "Health for All by the year 2000" never materialised. And the main reason that it never happened is simply that health is not easily accessible and definitely not affordable to many citizens of the world. So as we are gathered here today, we must understand that the issues we are dealing with are not exclusively a South African phenomena, but are global. I don't know of any Minister of Health today who is not worried about affordability of healthcare within his or her country.

To demonstrate my point, let me quote from the acceptance speech delivered at the 65th World Health Assembly in Geneva, Switzerland, on the 23 May 2012, by Dr Margaret Chan, on being elected to her second 5 year term as the Director General of the WHO. She was addressing the issue of Universal Health Coverage, and I quote: *"Universal coverage is the umbrella concept that demands solutions to the biggest problems facing health systems.*

That is: rising health care costs yet poor access to essential medicines, especially affordable generic products; an emphasis on cure that leaves prevention by the wayside; costly private care for the privileged few, but second-rate care for everybody else; grossly inadequate numbers of staff, or the wrong mix of staff; weak or inappropriate information systems; weak regulatory control, and schemes for financing care that punish the poor."

Yes, what she said describe perfectly what is happening in this country. If you did not hear me well, let me repeat some of her points, she is talking of a costly private healthcare for the privileged few but second-rate care for everybody else. Weak regulatory control and scheme for financing care that punish the poor.

We are gathered here today to deal with the very same concerns raised by the Director General of the WHO. It has become an undeniable fact that healthcare is simply unaffordable to the majority of our people.

Prices have escalated to uncontrollable levels, and due to the absence of regulation, it may not be dramatic or an over-exaggeration to describe the situation as the law of the jungle, where the principle is survival of the fittest.

The arguments I hear in the media, and in various stakeholder forae, is not whether the cost are high or not, but rather who is responsible for this state of affairs. Most disappointing is the fact that all stakeholders are exonerating themselves from any form of blame. A culture is being cultivated that says that if I am not to blame, then I am not obliged to provide solutions.

In recent weeks, there has been unprecedented finger-pointing, accusations and counter-accusations. There is even a trend developing, whereby some of the role players are commissioning their own researches with an express aim that the results will exonerate them in the eyes of the public and apportion blame to the perceived enemy of those who commission the research.

The most recent one which was going to be laughable if it was not tragic, is that the elderly citizens of this country are solely blamed for the ever escalating cost of healthcare.

Are we supposed to get rid of the elderly in order to solve this problem?

I think it will help us to start sifting fact from fiction, and fact should never depend on who has the power to commission their own personal research. All research must be conducted in the public good, and hence has to be fiercely neutral and completely scientific in order to arrive at an unpolluted truth.

Fact number one: We are a country, which is spending more money on health but having poorer outcomes – that is a fact;

Fact number two: The WHO has recommended that for better health outcomes, countries spend at least 5% of their GDP on health. As a country, we have far exceeded the recommended amount, because we are already at 8.5% of the GDP. Within the BRICS countries, it is only Brazil which is ahead of us. But all of the four BRICS countries have better health outcomes than us, despite lacking behind in expenditure of health as percentage of GDP.

I am frequently quoted by some in the media, as always blaming private healthcare and accusing them for uncontrolled commercialism. The concept of uncontrolled commercialism is not the concept of Dr Aaron Motsoaledi. It is the World Health Report released by the WHO in 2008. This report details three trends that undermine the improvement of health globally, and is not directed at South Africa but to any part of the world where such trends may be found.

The three trends are:

- Hospital centrism, which has a strong curative focus
- Fragmentation in approach which may be related to programmes or service delivery
- Uncontrolled commercialism which undermines principles of health as a public good

We know for a fact, that the USA spends more money on health than any country in the world, but lacks behind many countries in as far as the health outcomes are concerned. This President Obama has accepted as a big problem, and that is why he has come out with a solution that is now called “Obamacare”. Facts at our disposal are that the USA got into this situation because of uncontrolled commercialism. The bad news is that in South Africa we do not have one but we have all these 3 negative trends.

We have got hospital centrism with a very strong curative focus, and we think little of Primary Health Care (PHC) which has got a strong preventative and health promotive focus.

We still have fragmentation which we have thought we had done away with after Apartheid. And of course we do have this uncontrolled commercialism which is consuming the healthcare system. The uncontrolled commercialism of healthcare in South Africa is not confined to the private healthcare, it is also prevalent in the public healthcare system.

In dealing with these issues and arriving at the truth, there should be no holy cows. As a Minister, I am not going to choose the route which many stakeholders have chosen, viz ducking and diving and finger-pointing. It is not my style. Neither is it my style to shy away from the truth, regardless of how powerful the individuals or entities are.

Let me start in the public sector.

The public health sector has got a problem of deteriorating quality of healthcare. This is a very sore point in our country. I am working around the clock to deal with this issue, and no stone will be left unturned. Part of the reason for this deteriorating quality of healthcare, is often lack of basic essentials which no healthcare system can do without.

This lack of basic essentials has been caused in part, by uncontrolled commercialism, whereupon some individuals within the public healthcare system insidiously replaced the healthcare system with a tendercare system, whereby tenders come first and healthcare last. As South Africans we are going to have to face this problem head-on.

By now we have identified 5 main cost drivers in the public health sector. These are:

- Compensation of employees;
- Pharmaceuticals;
- National Health Laboratory Services (NHLS);
- Blood and blood products; and
- Equipment and devices

Except for the compensation of employees and blood and blood products, the rest are driven by uncontrolled commercialism. This situation did not roll in on the wheels of inevitability, but is a result of wrong choices and tendencies which were allowed to proliferate over the years. We are determined to reverse these tendencies.

What about the private healthcare? Each time I opened my mouth to complain about the ever-escalating costs in private healthcare, I am immediately and rudely reminded that the only problem in this country is the poor quality in public health and that there is nothing wrong with private health because they provide superior quality.

Yes, I will accept upfront again and again, that the public health sector is riddled by problems of deteriorating quality. But I have a question to ask. How does that automatically translate into uncontrollable ever-escalating private healthcare which by now has reached dizzying heights?

By the way I am not the first person in position of authority who has raised this question. It has been raised by more authoritative people than me, but I guess I am being targeted because I relentlessly placed this malady in the public arena.

Everytime the issue of NHI comes up for discussion, some jump to the comparison of public and private healthcare. I have mentioned many times and I want to mention it again today, that NHI is not a beauty contest between private and public health, but is rather a novel way to look for solution as elaborated upon by Dr Margaret Chan of the WHO.

Let me take you to a report compiled by Judge Jody Kollapen when he was still Chairperson of the Human Rights Commission (HRC). That report is entitled “Public Inquiry, Access to Health Care Services”. It was published in 2009.

That Inquiry was conducted by the HRC in order to find out whether the healthcare sector respects Section 27 of the Bill of Rights. The Bill of Rights unequivocally defines health as a right.

This is what the report says:

“Costs within the private sector rose steadily between 1990 and 1998, however they rose more steeply after 1998 and this was largely consistent with the period in which the private hospital market became heavily consolidated into 3 hospital groups, which continue to dominate in terms of buying and building new hospitals. The cost escalation and overprovision is a consequence in part of the fact that regulation of the private sector has focused more on medical schemes and less on providers. As a result, the potential for profit, rather than need appears to have been the deciding factor in the expansion of private sector facilities. Overprovision is also found in the fact that some of South Africa’s private hospitals are better resourced with equipment than many rich countries.

High costs appear to have been fuelled by unethical practices in which private hospitals overcharge on surgical supplies and materials. In July 2007 accusations were levelled by the BHF and supported by the country's biggest medical aid provider, Discovery, suggesting that inflation on items such drip sets, gloves, syringes and suture materials were costing medical aid companies about R2 billion per year. The Department of Health published (non-binding) regulations requiring all private healthcare providers to submit details of their costs.

The rapid increase in private sector costs, resulted in dwindling number accessing private healthcare and the consequent increased burden on the public sector. Medical aid coverage decreased from 14.9% to 14% between 2004 and 2005. Between 2000 and 2010, the increase in the population served by the public sector is anticipated to increase to 7 420 741 compared with 680 044 served by the private sector.

Aware of the challenges, the Department of Health has various measures in place to try and contain the negative impact of the private sector on the healthcare system as a whole. Measures include the amendment to the Medical Schemes Act, the Health Charter and proposals encompassing the National Health Insurance.

Medicines pricing regulations has resulted in a 15%-20% reduction in the cost of medicines prices at the factory, and there is good evidence to support increased volumes of drugs purchased in the private sector resulting from lower prices. However, regulation of private sector has proved to be challenging, and the NDOH has encountered fierce resistance from some private sector stakeholders to their efforts to reduce inequities between the private and public sectors."

What is in this report was not said by me, but by the Human Rights Commission under Judge Jody Kollapen.

Another very important organ of our society, is the recently developed National Planning Commission, chaired by Minister Trevor Manuel.

In their National Development Plan 2030, recently adopted by Parliament, in Chapter 10 of this Report, entitled "promoting health", they enumerated 5 of what they regard as key points in health.

Point number 5 states that "a national health insurance system needs to be implemented in phases, complimented by a reduction in the relative cost of private medical care, and supported by better human capacity and systems in the public health sector."

In a report to the Portfolio Committee on Health of Parliament, on 27 July 2011, the Council for Medical Schemes reports that hospital costs are the key cost drivers and like the Human Rights Commission, they report on market concentration as a problem. As a further problem, the coined a term “the medical arms race”, which as I have said earlier the HRC has referred to as follows: “Overprovision is also found in the fact that some of South Africa’s private hospitals are better resourced with equipment than many rich countries.”

In the same report they produced a graph which shows that the cost has risen sharply from 1998, this corroborating the findings of the HRC. In the same report it further produces a graph proving that increase in cost is not explained by aging in population as claimed by some reports.

As it is now, we all know that medical scheme premiums have been increasing by more than CPIX for more than a decade. What does not make sense is that while the premiums are rising, the benefits are steadily declining. Co-payments levied to patients are increasing in both quantity and the amount charged. Logically, every member of a medical aid scheme will blame their medical aid. They believe that their medical aids are fleecing them.

But in February 2011, the BHF, representing 80% of the medical schemes of the country, wrote me an SOS letter complaining that in the 2009/10 financial year, all the medical schemes contribution have been claimed and exceeded by R2.5 billion.

This state of affairs has produced an untenable situation in the country, whereby medical aid schemes, in a desperate attempt to protect themselves, are busy reducing benefits. Employees on medical aid schemes in both public and private employment, read this situation as due to the fact that employers are short-charging them by providing what they believe are low medical aid subsidies as part of their remuneration. We know for a fact that this is not true because as I have just said, employers, both public and private have been subsidising their employees at the rate more than CPIX. But still, during every strike, whether in the public or private sector, employees are crying for more medical aid subsidies, while medical aids are complaining of their dwindling resources.

It is very clear that an Inquiry is needed to reach to the bottom of this confusion. This country cannot go on living under blackmail and uncertainty forever.

Where does competition fits in all this? The report from the Council for Medical Schemes, argues that if healthcare is defined as a market, it does not meet the requirements for normal competition. It says that the first requirement for normal competition is that there should be no barriers to enter or exit the market. But in health, hospitals require large amounts of capital or skills. It takes many years to train a healthcare professional. There are many regulatory interventions in training, registration, practice standards etc.

The second requirement for normal competition is perfect information. But the demand for healthcare is a derived demand – arising from the demand for health. The public has no knowledge of what is required to treat an ailment, it is the healthcare professional who has such knowledge.

The third requirement for normal competition are zero-transaction costs. But the cost of choosing a different hospital is huge. This becomes difficult when someone is not well.

The fourth requirement for normal competition, the report states, is homogeneous products. But healthcare, due to its very nature, has to be customised to meet the patient's needs.

It is very clear chairperson that in the present scenario in South Africa there is one and only one loser at all times – it is the patient.

Even if the Council for Medical Schemes comes up with innovations like the Prescribed Minimum Benefits (PMBs), in an attempt to protect the patient by forcing Medical Aid Schemes to pay in full for such conditions, the patient will still end up the loser, because premiums are just going to be increased and the patient is still responsible for that.

If the disease is not classified as a PMB, the Medical Aid Scheme will pay as little as possible, in what they claim is their right to shield themselves from exorbitant prices, the provider will just demand the rest of the money as cash from the patient. This of cause cancels the very fact that the patient decided to be a Medical Aid Scheme in the first place.

As the Human Rights Commission report shows, the tendency has always been to focus on the Medical Aid Schemes. Whether it is the Council for Medical Schemes or the Competition Commission, and recently the National Consumer Commission, the focus has always been on Medical Aid Scheme. This has left the providers, especially the large and powerful ones to do anything in anyhow they please.

I can go on and on and on, the patient is always the loser. I regard it as my role to protect the patient, and that is what I am here for.

The National Department of Health has a Constitutional duty to step in to develop an appropriate means of addressing the problem, ensuring that the private healthcare system is both sustainable and fair. The proposed market enquiry will provide a better understanding of the market, through an independent, expert assessment of the root causes of the problems that we are seeing. We need to understand whether and how these problems are related to competitive distortions in the market. Whether what we are witnessing is the result of the exercising of market power, or if it is a result of other factors such as increased utilisation (as is sometimes argued), or the consequence of a regulatory vacuum is yet to be determined. Once we have clear consensus and agreements on these issues we can start to develop a strategy to remedy this through the different tools that we have at our disposal including competition, policy changes and regulation. It is important for me to say that regulation of the private healthcare sector in this country is not unusual or sinister. For example, the telecommunication and energy sectors operate successfully under regulation and are critical sectors that provide public goods in our economy.

Regulation of certain sectors serves to empower and protect consumers in navigating the complexities of those sectors.

In healthcare, the foundation for regulation of the private sector is the Constitution of the Republic of South Africa. In particular, section 27 and section 7(2) require us as the government department responsible for health, to take all reasonable measures, including regulation, to progressively realise the right to healthcare for all. We have already taken such measures in relation to the pricing and quality of medicines, and continue to do so in other areas both in the public and private healthcare sectors. When we worked hard to reduce the price of ARVs, we were doing so solely in the interest of the patient. But in our ever present tendency towards uncontrolled commercialism, we were told that the pharmaceutical industry will suffer, there will be lot of job losses, everything possible was said for other people but never for the patient. But because we believe in what we are doing, we soldiered on. And the results? Chairperson, they were tremendous. We all know the glowing reports about South African that came out of Washington, in as far as the country has handled the AIDS Epidemic. It is not only about the glowing reports, but research has shown tremendous gain in as far as human capital is concerned. Reduction in Mother-to-Child Transmission, reduction in mortalities, and increasing life expectancy, stabilisation of the workforce.

These gains are tremendous for the whole country, even for the very same industries which we are accused of seeking to destroy.

The point I am trying to make here ladies and gentlemen is that most important resource in any country is the human capital, and in all our dealings and considerations, it is this human capital that must be protected, especially from the ravages of ill-health.

The National Health Act specifically empowers the Department to make regulations in relation to various aspects of the private healthcare sector. The National Health Act also recognises the socio-economic injustices, imbalances and inequities of health services of the past and the need to improve the quality of life of everyone, and seeks to do the following:

- unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
- provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;

- establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourage participation;
- promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans.

These are the Constitutional and statutory principles, underpinned by human dignity and equality, that must guide any steps we take.

It is for this reason that we welcome the Competition Commission's announcement that it intends to examine in greater detail the private healthcare market in South Africa. The Competition Commission has an enviable track record in using their economic and legal expertise to make markets fairer for consumers. Their investigations of abuse in markets across the economy from steel to bread have been premised on the ideal of making the markets fairer and more transparent, with consumers as the ultimate winners.

In addition, the community of competition practitioners here today, all potentially have a role to play in enhancing this debate and deepening our understanding of this market through constructive debate and research. It is our hope that using the skills and tools that the Competition Commission has at its disposal together with robust public engagement we will be able to see an independent and evidence-based picture of whether there are serious competition concerns in private healthcare and if there are, how best we can work together to address these problems. I urge all stakeholders to participate fully in the enquiry with the objective of ensuring a fairer and more sustainable healthcare system for all.

I wish to conclude my presentation by quoting from a speech delivered by Dr Margaret Chan, the Director General, on the 2 April 2012, when addressing Ministers of Health in Mexico, about Universal Health Coverage. She said:

"This world will never become a fair place all by itself. Fairness, especially in matters of health, comes only when equity is an explicit policy objective. Universal coverage is a clear pursuit of equity and social justice. Universal coverage is also a powerful equaliser".

“Moving towards universal coverage is never easy, but every country, at any level of development, and with any level of resources, can take immediate and sustainable steps in that direction”.

I am ending with this quotation because I am on record as having said that for NHI to survive in South Africa, two pre-conditions must be met. Firstly, the quality of health in the public healthcare system needs to drastically improve, the public healthcare system must be completely overhauled. The second pre-condition is that private healthcare costs need to be regulated, and I believe that we are here today to look into that.

I THANK YOU