



H e a l t h M a r k e t I n q u i r y

Promoting Healthy Competition

SUMMARY OF RESULTS FROM THE HEALTHCARE CONSUMER SURVEY

18 November 2016

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1 BACKGROUND

Imperfect¹ and asymmetric² information in any market is seen as a major factor that weakens the ability of consumers to encourage competition that drives efficiency and quality. In most markets, information on quality and price are what allow consumers to make choices between providers. The question thus arises as to whether better-informed consumers/patients could lead to substantial improvements in health costs, quality and ultimately outcomes. The market for healthcare is, however, complicated. It is recognised internationally, in South Africa and by the Health Market Inquiry (HMI) that some level of information inequality will always exist between producers and consumers of any healthcare service. Nonetheless, access to information on price and quality can increase consumers' ability to choose; thus increasing their bargaining position and ability to make appropriate decisions. Conversely, when there are information failures, competition between suppliers is lessened resulting in poor outcomes for consumers regarding cost and quality.

It is important, as a baseline, to understand the degree to which consumers in the South African healthcare markets are informed. In this report, we are particularly interested in the experience of consumers of healthcare services and healthcare financing products (medical aid).

Due to lack of information consumers may struggle:

- in their ability to choose the most appropriate provider to deal with their health condition;
- to know which healthcare interventions are required and are beneficial;
- to choose medical scheme cover;
- to know what the appropriate price is to pay for a service or medical aid cover;
- to assess if they are getting the appropriate services and reimbursements from the schemes they do join; and
- to decide whose advice to rely on in making these decisions.

While the public hearings held by the HMI surfaced some issues that patients experienced, the evidence presented was fragmented, and the HMI, therefore, decided to gather additional

¹ Imperfect information: in reality, information has a cost of production and dissemination, so it is naturally not spread out to the entire population. Hence, in a situation of imperfect information, all parties to the transaction do not have full information. For example, a GP is likely to know more information about various treatment options than a patient; but even the GP does not know for certain which treatment will work best, in view of some unobservable characteristics of the patient's health.

² Asymmetric information: describes a situation where one party holds more information than another, and the party with the information can use it to take advantage of the other party. For example, individuals who purchase medical plans know more about their health status than the medical scheme. This contributes to the emergence of an adverse selection problem.

information. The information was collected via a consumer survey in which 1507 South Africans participated, over the period April 2016 to May 2016. The survey sought to understand the following:

- What information is available to patients in the private healthcare sector?
- How patients make decisions regarding service providers, e.g. the medical scheme, hospitals and doctors?
- The consequences of these decisions as elucidated in the consumer experiences.
- What additional information, if any, and in what form, patients would like to have to be able to make better decisions?
- What role do market participants (e.g. brokers, practitioners, funders) play as agents to consumers and to what extent do they disseminate information and advice?

Along with the consumer survey, the HMI sought to bolster the results and place them into context by making use of focus groups. For both the consumer survey and focus groups, the HMI focused specifically on consumers and their decision-making pathway in utilising private healthcare.

2 METHODOLOGY

2.1 Sample

The HMI made use of a service provider to conduct the survey. The HMI accepted quotes from public consumer survey companies in response to a brief and Insight Survey was selected as the service provider. The company maintains an invited volunteer panel of 38,000 South Africans whom they can access for any survey they conduct. The panel is broadly representative of the South African population, though it was noted that it is likely to contain people of the higher LSM, as the members required access to the internet to complete the survey. This was considered to be appropriate for the HMI purposes as these are also the people in South Africa more likely to have joined (and left) medical schemes. In general, individuals who have recently responded to a survey are excluded from the next survey to reduce interviewee fatigue. This meant that people who had just participated in another survey by the company were excluded for the purpose of the HMI survey. Panel members who had used medical care in the last 12 months were invited to participate (23,187 people) in the survey, and those who agreed were included. The HMI deemed a sample with a minimum size of 1500 to be sufficient to enable us to make valid conclusions. The sample was to include people who were and were not current medical aid members.

Six focus group discussions were held, and the groups consisted of people within determined age groups, and included both men and women and cut across race and income groups. Each group comprised 6 - 8 target market respondents that were recruited by professional recruiters. These recruiters approached people and interviewed them using a recruitment questionnaire. If these people met all the criteria, they were invited to attend the focus group discussions and were given a monetary incentive for their participation.

Discussions were held at research venues in Johannesburg and Cape Town and staff from the HMI observed the proceedings of the focus group discussions behind a one-way mirror. All discussions were digitally recorded. Focus group discussions were held for approximately 90 minutes and were facilitated by a professional moderator, who ensured participants fully engaged with the discussion process. The recruitment criteria for focus group participants are shown in the tables below.

Table 1: Group 1 (Cape Town and Johannesburg)

Mixed races
Adults 18-34 years (50% with children, 50% without)
50% Male 50% Female
Respondent must be on a medical aid
Must be able to understand and communicate in English

Table 2: Group 2 (Cape Town and Johannesburg)

Mixed races
Adults 35-59 years
50% Male 50% Female
Respondent must be on a medical aid and have used private healthcare (doctor or hospital) in the past 12 months
Must be able to understand and communicate in English

Table 3: Group 3 (Cape Town and Johannesburg)

Mixed races
Adults 18-34 (Johannesburg)
Adults 35-59 (Cape Town)
50% Male 50% Female
Respondent must not currently be on a medical aid, but must have used private healthcare (doctor/ hospital) in past 12 months
Must be able to understand and communicate in English

2.2 Data collection instruments

The survey was designed with consideration of similar surveys conducted in other countries to allow for international comparability and included questions specific to the South African environment. The HMI compiled and pre-tested the survey and then provided it to the service provider to place into an online format.

The survey collected data on:

- demographics (age, sex, level of education, employment status, annual family income);
- whether the respondents knew the difference between medical aid schemes and health insurance;
- whether they were members of a medical scheme and if so, if they were the principle member, adult dependant or child dependant member;
- whether they were ever a member of a scheme. We collected information on how long they had been a member and how they chose their scheme. They were also asked how many people in their households also belonged to a medical aid scheme, and if some members of the household were not on medical aid, why that was the case;
- whether they understood the cost implications of membership before joining, if they believe they had made the right choice and if they were still a member;
- the reason(s) for leaving, for those who had left their scheme;
- the likelihood that they would switch schemes or opt for a lower cost option;
- their claims experience:
 - if they had to go through any pre-authorisation process;
 - who, if anyone assisted them with the pre-authorisation process;

- if they landed up paying for anything that they had anticipated the scheme cover would have paid for;
- whether they had used a broker to select a medical scheme and for those who did we asked:
 - how many medical schemes options their broker offered them; and
 - if they felt the broker provided sufficient information on the costs and benefits of the selected package;
- whether they had used a health service and if so:
 - what service they used (e.g. doctor, hospital, emergency room, etc.);
 - the reason for their visit (e.g. routine check-up, chronic condition, acute health problem); and
 - how they paid for the service;
- their prior knowledge about the quality of the service they were using, if anything would influence them to change provider and their source of information on the quality of the services they use;
- whether they believed that there are differences in quality between providers (doctors and hospitals);
- whether they would be happy to have their health records shared between various providers who treated them.

In the focus groups, we explored similar issues (medical aid experience, experience with pre-authorisation processes, brokers, experience with hospitals and doctors and their perceptions about variability in the quality of services available to consumers). In this regard, we were able to explore these issues in more detail. For example, we could explore what people understood to be the distinction between health insurance and medical aids and what factors influenced the various decisions they made about scheme membership.

2.3 Demographics and sample selection

The quantitative survey received responses from 1507 people. The desired sample quota for the HMI was to have 66% of respondents belonging to a medical aid at the time of the survey and the remaining 34% not members of a medical aid. The age of the respondents is summarised in the table below:

Table 4: Age distribution of survey study sample

Age range in years	% of sample in this age category
18-24	19%
25-34	36%
35-49	28%
50+	16%

The respondents were distributed amongst most South African provinces as follows: 41% Gauteng; 20% from KwaZulu-Natal; 16% from the Western Cape and 23% all other provinces.

3 RESEARCH RESULTS

3.1 Medical scheme experience

This section discusses the experience of consumers of private healthcare services with regards to medical schemes. It includes considering the consumers' understanding of the legal distinction between medical aid and health insurance, and their decision to join or leave a medical scheme.

3.1.1 Legal distinction between medical aid and health insurance

Almost two-thirds of respondents (57.4%) reported that they were aware of the legal distinction between medical aid and health insurance, 31.0% believed that there was no difference and the remaining 11.6% did not know. The focus groups allowed the HMI to explore this further and this revealed that participants were largely unaware of the legal difference between medical aid and health insurance. For example, when listing names of medical schemes, health insurance products were also listed, and this was not queried by any of the group members. Comments included that:

"I thought health insurance wasn't South African; it's not a term I know".

And,

"Health insurance is run by the government to ensure everyone has cover".

Other participants stated that they were confused about the two terms.

Thus while the quantitative data indicate that many people reported knowing the distinction, a simple yes/no answer may have been too blunt an instrument to use to assess if their knowledge is correct or not. When this was probed in focus groups, it was clear that there was in fact uncertainty on the distinction.

3.1.2 Membership of medical scheme

When asked the question as to whether they had ever been a member of a medical scheme, 84% of all respondents to the survey (n=1507) replied yes, while the remaining 16% responded no. Of the 84% that have been members of medical schemes (n=1264), 62% indicated that they had been a member for more than five years and 28% had been members for between two and five years. Of the 1264 respondents who have been part of a scheme at some point, 79% were members of schemes at the time of the survey.

3.1.3 Perceptions of medical aid schemes

During the focus groups, the respondents were asked to provide their perceptions of medical schemes. The associations that came under discussion in relation to medical schemes were negative for most consumers in the focus group discussions. These sentiments were iterated by medical aid and non-medical aid groups alike, with one participant stating that medical aid was '*a necessary evil*'. Other responses include:

"I can't entertain that amount of money coming off",

"Always excess fees to be paid",

"Expensive", and

"Exceptionally high rates".

Another theme that emerged besides the cost of medical aid, was about complexity. Participants indicated that there was complexity in choosing a scheme and understanding the information provided in that regard.

3.1.4 How members selected a medical scheme

Table 5 below revealed that 50% of respondents who have ever been on medical aid had selected their medical schemes through their employer. Eighteen percent (18%) of those had selected the scheme on their own, without assistance from a medical aid broker or their employer. Only 12% chose their medical scheme with help from a broker or employer. It is notable that although employers may or may not have offered real help to employees in selecting the medical scheme or scheme option, employers can and do use brokers to assist

in deciding which particular schemes are made available or are presented to their employees. It is thus possible that there is an overlap, where respondents cited the employer as the entity helping to make a choice, because the employer may itself be making use of a broker.

Table 5: Choice of medical scheme

How medical scheme was chosen	Percentage
Through my employer	50%
Through a Broker, agent or adviser	12%
By myself without assistance from broker/employer	18%
I am not the primary member (on my partner's scheme)	10%
I am not the primary member (on my parent's scheme)	10%

Factors that influence choice were solicited during the focus groups. 'Cost' and 'Range of Options' were two primary themes that emerged from the focus group discussions. Cost seemed to be the primary decision-making factor for the younger group (age 18-34), while the range of medical scheme options appeared to be the main factor for the older groups (age 35-59). Other thematic factors evident across all groups were the choice of a doctor or hospital and value for money. Individual attention was a choice factor mentioned solely by the older group.

Also, participants in the focus groups stated, that their choice of a medical scheme was based on their fear of public hospitals, very high medical bills and family responsibilities (e.g. having children). Age-related factors, health scares like a stroke, and other heart-related diseases were also mentioned. One of the respondents stated that:

"Getting older, it's a risk not to have medical aid".

Participants in the focus group discussions agreed that the process of selecting a medical aid plan and the information available from medical schemes are complicated. Participants stated that:

*"If you look at the amount of different plans there are, it's a minefield to choose", and
"You can choose the wrong plan".*

About information availability, a participant commented that there are;

"Lots of terminologies and you have to kind of decipher".

Another stated that there is;

“A lot of information – It’s too much”.

Participants also stated that they got confused at times because not only were the scheme plans complex, the plans also kept changing. One participant noted:

“You always need to check if you are covered for something. It changes all the time.”

3.1.5 Reasons for family non-membership

The respondents of the survey were asked to identify if all the members of their family were on medical aid and 43% of the respondents stated that all their family members were on a medical aid. For those who had family members who were not members of a medical scheme, reasons included:

- no longer being able to afford the contributions (15%);
- now no longer a child dependant and could not afford it (14%).

3.1.6 Consumer understanding of medical scheme options

Consumers were asked in the survey about their knowledge of the cost implications and benefits provided for in the various options across medical schemes. Seventy-six percent (76%) of respondents on a medical scheme stated that they understood the cost implications and benefits of options provided across their medical scheme before making a selection. During the focus groups, the participants’ understanding varied. Certain participants stated that they had poor knowledge of the cost and benefit implications of the medical scheme options. They indicated that they did not fully understand the cost implications and benefits of the scheme options. One of the focus group participants stated:

“I got confused between the 300% and 100%. So, I’m like, you’re going to offer us the same thing. What is the difference between 300% and 100%? I have no idea”.

Some other participants seemed to have a clearer understanding of the cost implications and benefits of their medical aid options. A participant stated:

“I took every plan and put it together and compared and saw what you got for what you’re paying for. I had a friend that helped a bit ... she’s a broker, so she also put a few medical schemes together and gave me a bit of advice”.

Another stated:

“When I chose it, I had to look at the benefits and make a decision, so I was aware of that”.

Access to the internet and computer literacy seemed to be a major factor. Participants said:

“I went on the Internet and Googled affordable medical aids,”

“Everything was just there (on the Internet). Then I’d just call them every now and then to find out every detail”.

3.1.7 Confidence in medical scheme choice

Sixty-seven percent (67%) of the respondents who had indicated being part of a scheme at some point agreed that they felt confident they had made the right selection of medical aid. More detailed insights from the focus groups illustrated how some participants felt a lack of trust, a ‘hassle factor’ in making a truly informed choice, and concerns about affordability respectively:

“I’m not happy. I know I’m getting ripped off”,

“I think there could be better out there. It’s quite a hassle to look and change, so I think it’s something people don’t really do” and,

“I am not sure how much longer I am going to be able to afford [Scheme name withheld].”

Other participants were more confident in their medical scheme choice. They stated:

“Yes, the first month all 3 children were sick, and [Scheme name withheld] paid”,

“Yes I’m happy” and

“Very happy with [Scheme name withheld] Paid R135 000 for my granddaughter”.

3.1.8 Reasons for leaving a medical aid

The 21% of survey respondents who were no longer a member of medical aid, even though they were at some point, were asked why they left. The results, presented in Table 6, reveal that 41% of respondents left their medical scheme because it was no longer affordable. This was followed by 13% who were members through an employer, but contributions became unaffordable after changing employment. Other reasons for leaving medical schemes included a change of job (11.6%), unemployment (11.2%), medical aid not being good value for money (5.6%), and exclusion due to health status (0.4%).

Table 6: Reason for leaving medical scheme

Reason for leaving medical scheme	Percentage
No longer affordable	41.0%
I/my partner changed jobs	11.6%
I/my partner became unemployed	11.2%
Not good value for money	5.6%
Was on my parents' medical scheme but then left home	9.3%
I wanted to stay but my medical scheme terminated my membership	3.0%
Was a member through an employer, but contributions became unaffordable after changing employment	13.1%
Have no dependants and therefore not concerned about healthcare needs	1.9%
Was excluded from being a member due to health status	0.4%
Others	3.0%

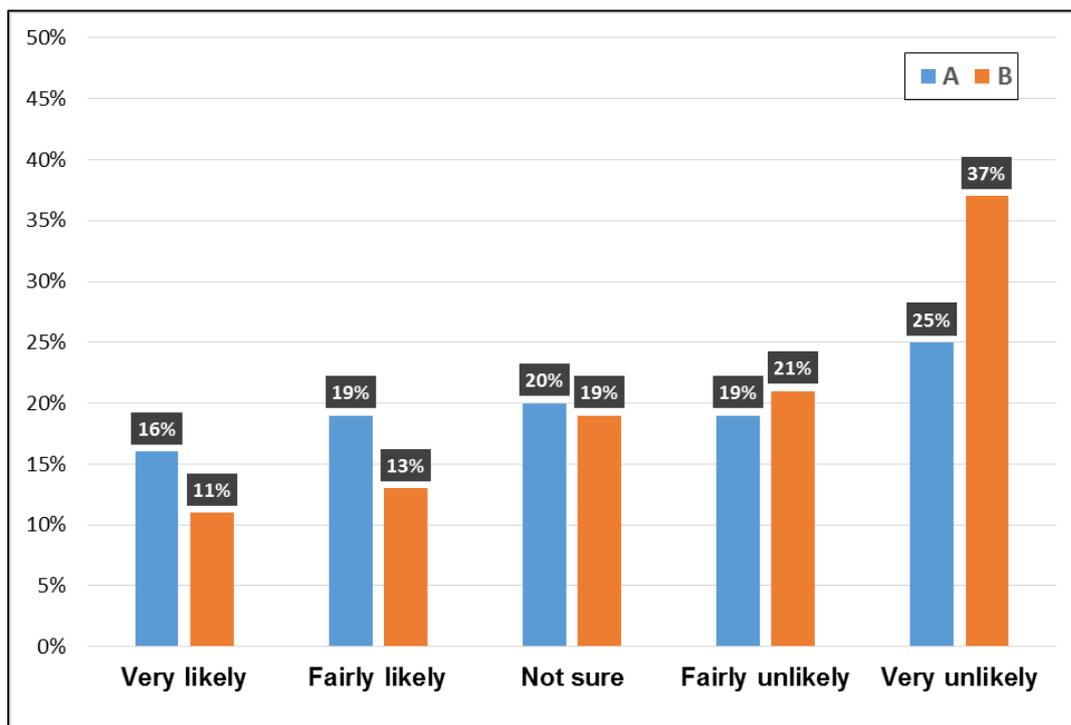
Responses from the focus group discussions reinforced the findings from the survey. There was a consensus amongst the non-medical scheme member sample that their primary reason for not being on a medical scheme was due to high medical aid premiums. Statements such as the following were made during the focus group discussions from those who had previously been on a medical scheme:

- *“It is too expensive now”.*
- *“I was on a medical aid; my company contributed towards half of my premium, and I had to pay the other half. Then I changed jobs and so I no longer had it”.*
- *“Last time I was on a medical aid, I was 22. I was on my parent’s medical scheme... I really meant when I said that I don’t really need it and I can’t afford it, plus I feel it’s not value for money”.*
- *“I am single, and on my salary, I cannot afford it”.*
- *“Because when I was working for the bank, I got the benefit of being on it”.*

3.1.9 Likelihood of switching to lower cost option or changing schemes

Survey respondents who were on medical aid were asked if they were likely to switch to a lower cost option. Twenty-five percent (25%) of respondents stated that it was very unlikely that they would switch to a lower cost option for the next year. On the other hand, 16% indicated that they would be very likely to switch to a lower cost option over the next year. In response to another question, 37% indicated that they were very unlikely to leave their medical aid over the next year. While 11% indicated that they were very likely to leave (Figure 1). This suggests that despite the challenges consumers enumerated with being on a medical aid, they were still going to maintain the status quo of remaining with their medical aid plans/options. This also reflects the relative inelasticity of medical aid cover.

Figure 1: Likelihood of switching scheme option or leaving medical scheme/plan



A = Likelihood of switching to a lower cost option/plan over the next year

B = Likelihood of leaving your medical scheme over the next year

The focus group discussions shed some light as to the factors that may be keeping members of medical aid from switching schemes or buying down. The responses from the focus groups show that though some participants were willing to switch to a lower cost plan/option within a scheme. Administrative difficulties and the fear of losing medical savings deterred others from switching to another medical scheme. Younger participants expressed caution towards switching plans, as they were concerned about losing savings. Some participants were unaware of annual reassessments, while others refrained from switching altogether due to administrative inconveniences and anxiety of unexpected consequences.

A participant stated:

"...I'm also worried about if you've only been on for six months and you leave you could lose all your savings then you have to pay all the money back or do you owe them money because now you're leaving in the middle, so I'm very scared about that".

Another participant added:

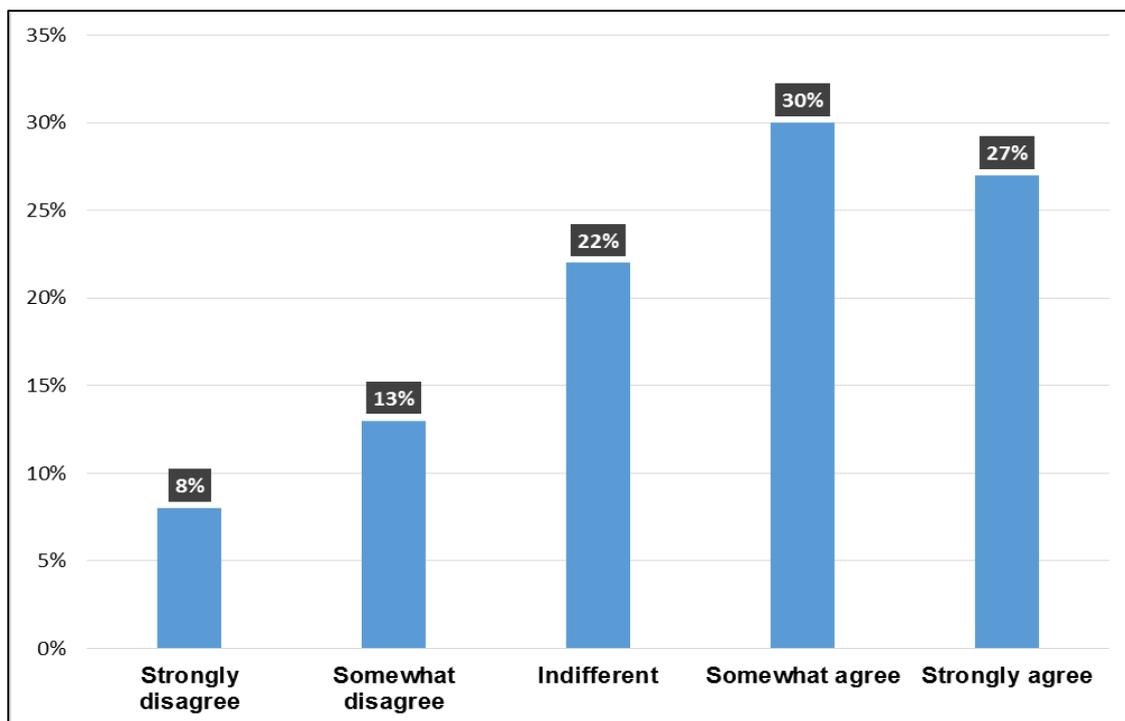
"It's not easier to go out looking, though. I think it's just easier to stay".

The statements made during discussions provided context to the results of the survey. Fewer people indicated in the survey that they would be willing to switch schemes or options/plans and the focus groups revealed that this might be due to a lack of knowledge or fear of the consequences.

3.1.10 Claims and refund of medical treatment expenses

The survey results reveal that consumers found it easy to claim back money spent on medical treatment. Figure 2 below shows that 57% (30% somewhat agree and 27% strongly agree) of respondents reported no problems claiming back funds from their medical scheme when they paid out of pocket. On the other hand, 21% of respondents (13% somewhat disagree, and 8% strongly disagree) disagreed.

Figure 2: No problems with claiming back funds



The focus groups discussed the kinds of problems that people experienced in claiming from medical schemes. One of the participants said:

“What happened is, I went to hospital, and on the day of admission there is a fee that you pay up front. Your medical aid does not pay, so I had to pay from my own pocket. So I waited and waited, and they said only when the bill had been settled by the hospital would they reimburse me”.

Another participant recalled how they were involved in an argument with their medical scheme as they were required to pay cash up front.

Also, information from the survey on unexpected medical expenses incurred, indicated that 60% (32% strongly agree and 27% somewhat agree) of the respondents agreed that they had faced medical expenses that they had expected the medical scheme to cover. Nineteen percent (19%) (10% strongly disagree, and 9% somewhat disagree) of the respondents did not agree. Eleven percent (11%) were indifferent while the remaining 9% did not respond.

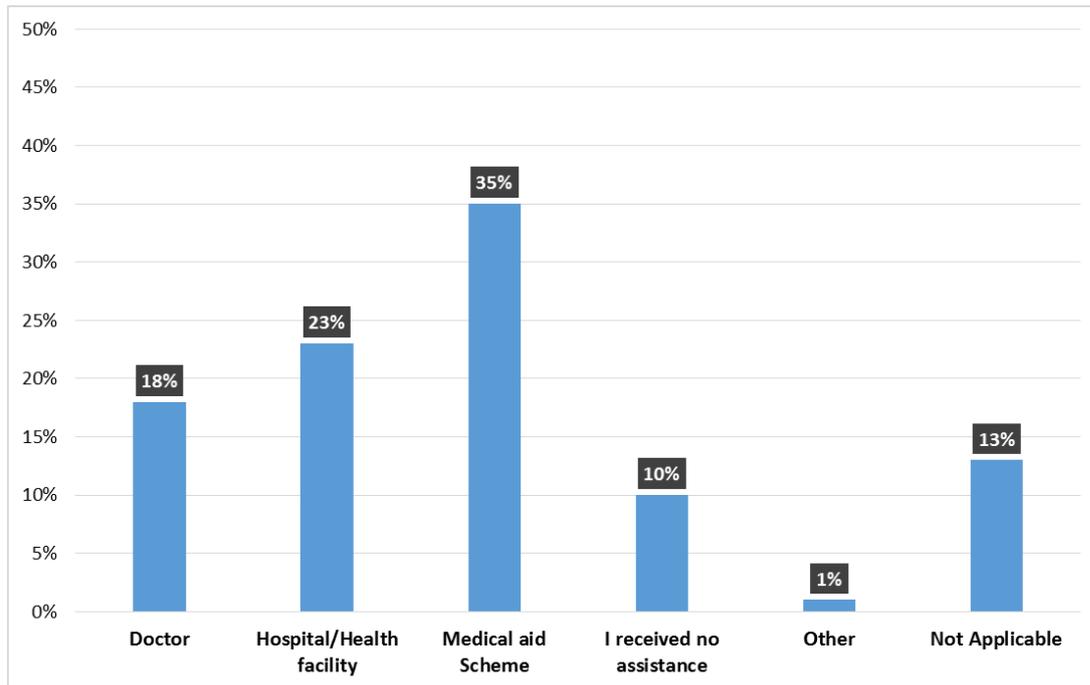
3.2 Pre-authorisation processes

The HMI's research revealed that for certain interventions (e.g. admissions to private hospitals and particular investigations), medical schemes require consumers of healthcare or members of the scheme to get pre-authorisation. The process differs between schemes.

For consumers who had been admitted in the past year, the consumer survey and the focus groups explored the relative ease with which members get pre-authorised and the stakeholder in the healthcare sector (hospital facility, doctor, broker or medical scheme) who assisted with the process.

Consumers were asked in the survey, who had assisted them with the pre-authorisation process. Figure 3 reveals that 35% of respondents who were currently on medical aid stated that the medical scheme helped them with the pre-authorisation process. Twenty-three percent (23%) were assisted by the hospital or healthcare facility they visited. Respondents were further asked if they were comfortable with the outcome of the pre-authorisation process; 65% of the respondents who were currently on medical aid stated that they were comfortable with the results of the pre-authorisation process. Eleven percent (11%) were indifferent, and another 11% were not comfortable with the process.

Figure 3: Assistance with pre-authorisation process



3.3 Medical scheme brokers

In the survey, sixty-three percent (63%) of respondents on a medical scheme said that they did not have a medical aid broker, 25% stated that they did have, and 12% were unsure. Similarly, most participants in the focus group discussions indicated that they did not use a broker. Participants were then asked how often they had interacted with the medical scheme broker in the past year. Fifty-six percent (56%) of respondents who said they used brokers (n=255) had rare communications with their brokers over the past 12 months. Sixteen percent (16%) had not communicated with their brokers at all over the previous 12 months, and 28% indicated that they had communicated often/frequently with their brokers. Sixty-six percent (66%) of those that used brokers stated that their broker presented them with between 2 and 5 medical schemes. Fourteen percent (14%) said they were presented with more than 5 options of schemes. Ninety-two percent (92%) of those who had used brokers felt that their broker had provided them with adequate information on the costs and benefits of the package they chose.

The focus groups revealed a negative perception of medical aid brokers across both medical aid and non-medical aid members. Some participants said they felt brokers were biased and others simply did not trust brokers. Brokers are perceived as solely interested in trying to earn

commission from prospective clients. There was a clear sense of unwillingness to use brokers. A respondent stated:

“I don’t (trust them). Because they make it for them to get the extra bucks. That’s why I like to rate for myself at the end of the day”.

Another participant added

“I don’t think they are willing to offer you three different companies; I think they have a biased opinion”.

A broker is seen to be very similar to “a salesman.” A respondent stated

“He will then sell you the one that best suits him at that moment.”

However, there were also positive experiences:

“They definitely make things easier. Instead of me reading a 30-page [Scheme name withheld] document, I can ask them if they think Essential is what I should be on.”

and

“My broker fought for me to get a C-Section.”

Those with positive experiences perceived their brokers to be genuinely interested in their wellbeing and they were also of the view that brokers made things easier. Based on the discussions it was evident that younger respondents were unaware that they were paying a monthly fee for a broker as part of their medical aid premium.

3.4 Medical practitioner and hospital experience

A section of the survey focused on respondents who had interacted with the private healthcare sector in the past 12 months. Seventy-five (75%) of respondents who completed the online survey had accessed a private doctor or hospital within the past 12 months. Twenty-five (25%) of respondents had not.

The proportion of people who had accessed private doctors and hospitals in the past 12 months was lower among the respondents aged 18-24 years (67.7%) and higher among those in the age group 50+ (78.6%). Fifty percent (50%) of respondents (both those with and without

medical aid cover) that had accessed the private sector in the past year had done so for minor ailments such as flu, headaches, etc.

During the focus groups, a theme that emerged about using private healthcare was the cost. Those not on medical aid expressed frustration at the cost of their respective private treatment, while those with medical aid expressed dissatisfaction with having to pay money over and above what medical aid would cover.

The participants in the focus groups were questioned about the factors that influenced their decision on which doctor or hospital to go to (once on a scheme). Three primary factors emerged: (1) (quality of) service; (2) reputation; and (3) location. It was also mentioned across the groups that in the event of an emergency, the choice became irrelevant due to time pressure.

Associations that come to mind when thinking about 'private hospitals' for most participants were positive across all focus groups. 'Quality service' was the most prominent theme, which was sub-divided into 'medical service' (i.e. quality of medical care and technology) and 'non-medical services' (i.e. hospitality, individualised attention). This was true for private out-of-hospital healthcare as well. The single negative theme, which emerged, was 'high costs'.

Participants of the focus groups that were on medical aid perceived public healthcare negatively. This mistrust proved a fundamental factor in the decision to join medical schemes. Comments included:

"News stories of babies who have died because they didn't get enough care."

"No compassion."

"If you don't have medical aid you are screwed."

"Lack of educated nurses."

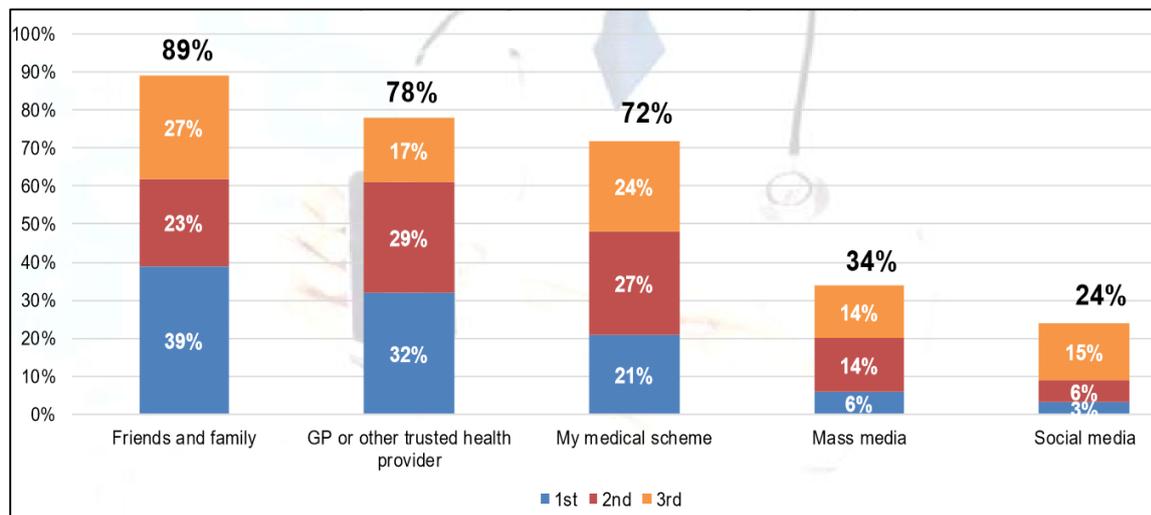
3.5 Information availability

3.5.1 Main sources of information for consumers

The majority of survey respondents stated that their primary source of information on doctors and hospitals was from friends and family. This source was ranked first by 39% of respondents (See Figure 4 below). This was followed by information from their GPs or other trusted health providers. This was ranked first by 32% of respondents. The third most popular source of

information for respondents regarding hospitals and doctors was from their medical scheme (21%).

Figure 4: Sources of information on hospital and doctors



3.5.2 Information on quality and cost of healthcare services

Respondents were asked if they had received sufficient information on the costs of care from their doctors. Seventy-three percent (73%) of respondents who had accessed private healthcare in the past 12 months (n=1128) agreed that they received sufficient information on the costs of care they received from their doctors. Twenty-seven percent (27%) did not agree that the information they received on the cost of care from the doctor was enough. In addition, 59% of respondents who had accessed private healthcare agreed that they received sufficient information about the costs of care at the hospital they attended, while 41% did not agree.

In relation to information provided on the quality of care by doctors that consumer had consulted with or been treated by, 75% (39% somewhat agree, and 36% strongly agree) of respondents agreed that they had sufficient information on the quality of care provided by their doctor. Concerning information on the quality of care furnished by the hospitals 64% (34% somewhat agree, and 30% strongly agree) agreed that they had received sufficient information.

Upon further probing at the focus group discussions on information on the cost of services, the participants stated they had not adequately been informed upfront of the costs, but only received the information after the event. The focus groups differed to the survey in regards to the timing of when information on the cost of care is shared. From the focus group discussions, it was evident that there were differing views on who should be tasked with providing

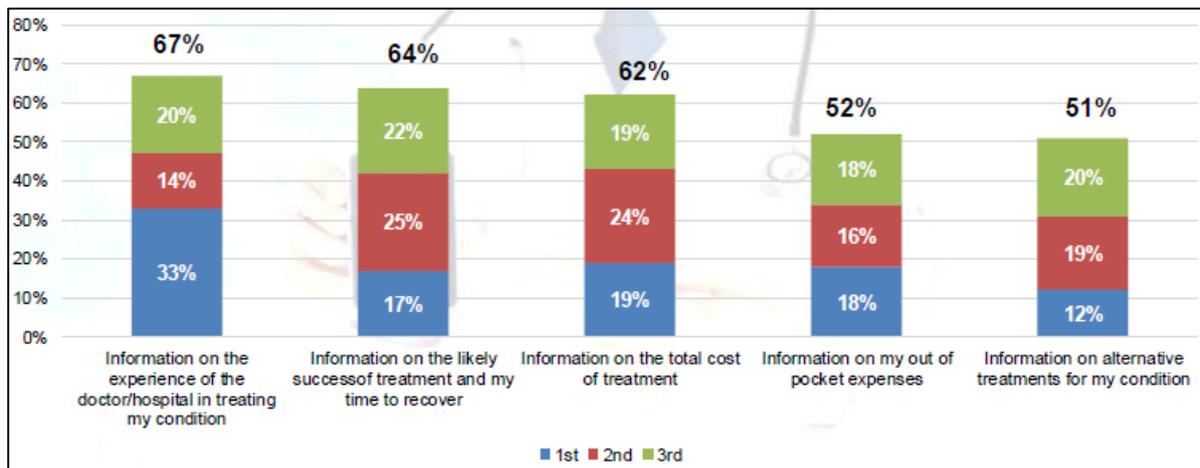
information on the quality and cost of healthcare services to consumers. Participants from the age group 35 – 59 felt that this should be the responsibility of brokers. However, the dominant feeling across participants was that the medical aid was not as directly involved in the provision of care as the hospitals are. It was thus the view of the participants that the responsibility of information provision on quality and cost of healthcare services should lie with the hospitals themselves. One of the participants from the focus group discussions disagreed stating that the medical aid should be charged with the overall responsibility of making information available. The respondent stated:

“The medical aid. We pay them, not hospitals.”

3.5.3 Information that would change choice of healthcare provider

Survey respondents, who had made use of private healthcare services in the last 12 months, were asked what factors would change their choice of healthcare provider. Sixty-seven percent (67%) of respondents ranked access to information on the experience of the doctor or hospital in treating their condition 1st, 2nd, and 3rd in importance if it were available. The breakdown of the ranking is as follows: 33% ranked this information as 1st, 14% as 2nd and 20% as 3rd. The figure below provides the remaining results:

Figure 5 Information that would change choice (Rank top 3)



3.5.4 Other information channels on hospitals and doctors

Participants across all groups and age categories in the focus groups indicated that they accessed information about medical care via the internet. A secondary channel of information was through word-of-mouth, which appeared to have a relatively strong influence on people’s decision-making activities across all groups (medical aid and non-medical aid). Some of the following responses highlight the channel consumers had used to access information:

- *“It was by referral, but I didn’t know what kind of quality of care I would be getting.”*
- *“On Google, you just type in the number and get all the information on that person.”*
- *“You go on your gut feel.”*
- *“My surgeon was actually recommended. That’s how I got my information”.*
- *“Mine was recommended by the doctor.”*
- *“It’s a bit of word of mouth.”*

The focus group discussions allowed the HMI to explore more fully the format of information that healthcare consumers would like. All age groups articulated the desire for online, user-friendly information. An extension of this idea, mentioned several times, was the development of a mobile ‘rating app’ about the accessibility of and current standards of doctors and hospitals. Also, in the discussions, there were suggestions for improvements in service delivery e.g. using a mobile application.

Table 7: Participants’ suggestion of preferred information channels

Preferred Channel	Respondents’ statements
Online	<i>“A blog where doctors are listed.”</i> <i>“Internet.”</i> <i>“Digital. They must stop this where the company sends you one pack a year. “</i> <i>“A TripAdvisor for doctors would be great.”</i> <i>“I would like to see reviews of doctors on Google.”</i>
App	<i>“How about an app that you can use to find that information?”</i> <i>“In this day and age, you can just access through an app.”</i>
Organisation/Bureau	<i>“A bureau.”</i> <i>“Belong to an association?”</i> <i>“There should be a medical board that can run this.”</i>

3.6 Perceived differences in cost and quality across providers

The survey contained questions on the perceived differences in quality and cost that consumers observed at consultations with practitioners and in-hospital care services. Table 8 shows the results of the questions on differences in cost and quality. The table revealed that consumers believe that both the cost and quality of healthcare services from the doctors and hospitals differ.

Table 8: Observed differences in the cost and quality of healthcare services

	Strongly disagree	Somewhat disagree	Indifferent	Somewhat agree	Strongly Agree
There are differences in the quality of treatment provided by various doctors	3%	2%	8%	30%	57%
There are differences in the cost of services provided by various doctors	2%	3%	9%	29%	56%
There are differences in the quality of treatment provided at various hospitals	2%	3%	10%	24%	61%
There are differences in cost of services by hospitals	2%	2%	9%	28%	57%

- Differences in the quality of treatment by doctors: 87% of respondents strongly agree or somewhat agree that there are differences.
- Differences in the cost of services by doctors: 85% of respondents strongly agree or somewhat agree that there are differences.
- Differences in quality of treatment by hospitals: 85% of respondents strongly agree or somewhat agree with this.
- Differences in the cost of services by hospitals: 85% of respondents strongly agree or somewhat agree with this statement.

From the focus group discussions, the HMI gathered that quality was understood to mean care that had a personal touch and that was hygienic.

The discussions in the focus groups indicated that there was a consensus amongst participants that there should be more transparency in the fees healthcare practitioners quoted. The respondents advocated for a level of standardisation of fees. However, others disapproved of the idea of standardisation.

Participants stated:

“The procedures are the same. The instruments and resources are the same.”

“Doctors are not fair. One doctor will charge you including medication and another will charge just for a consultation.”

Those opposed to standardisation stated:

“Each market is different; therefore, you can’t compare one area to the next.”

“Regarding experience, the doctor that just started practising cannot charge the same as the doctor that has been working a lifetime already.”

3.7 Access to patients’ health records

The quantitative survey asked respondents if they would be comfortable for their doctors to have access to all their health records, including treatments provided in the past by other doctors, medicines prescribed and tests undertaken. Sixty-five percent (65%) of respondents strongly agreed that their doctors should have access to all their health records. This is followed by 22% who somewhat agreed. Seventy-four percent (74%) of consumers also indicated that they would like to have access to their own health records followed by 16% who somewhat agreed.

4 CONCLUSION

This report forms part of a stream of work that the HMI is undertaking concerning imperfect and asymmetric information in healthcare. In particular, the HMI was interested in consumer’s experience in buying medical aid cover and using private healthcare services.

Based on the quantitative data, a majority of consumers in this survey had medical aid and seemed to be satisfied that they had sufficient information on the costs implications and benefits of the medical scheme options. Those who belonged to a medical aid indicated that they did not have very significant problems in choosing their scheme and were happy with their purchase. Fifty percent (50%) were assisted in making the choice of their medical scheme by their employer and 12% through aa broker. Of those respondents that no longer belonged to a medical aid, 41% indicated that this was because it was no longer affordable. The focus groups helped to put these results into context. It was evident from these discussions that the participants still found the choice of medical aid to be complex. Participants also indicated that they found medical schemes to be more of a grudge purchase and that it was expensive.

It was interesting to note that the ease with which the respondents stated that they could choose their scheme did not apply similarly to changing of schemes or switching to lower cost options. It was also of interest to note that in exploring this further, participants indicated that they feared losing their saving and benefits, dealing with administrative inconveniences and unexpected consequences.

Brokers are agents in this industry ostensibly to deal with just these issues, and it was of interest to note that the majority of people did not know they had nor did they engage with brokers. It may imply that the role of brokers is not very well understood. The qualitative data indicated a lack of trust in brokers but, for those that did use them, they found them useful. Given that every medical member pays a broker fee it is interesting how absent brokers seem to be in the mind of the consumer. Brokers' role in the industry is to be intermediaries between members and funders assisting consumers in their choice of medical scheme options and plans. A few consumers have highlighted the positive value received from brokers regarding guidance and continued support in their use of private healthcare services. Thus, they see brokers as part of the solution to the challenges of information in the private healthcare sector. Certain consumers have however highlighted the potential misalignment of interests between consumers and brokers as they view the payment terms of brokers as potentially clouding neutral and beneficial interactions that they should have with consumers e.g. in consumers' choice of which medical scheme to join.

The quantitative survey indicated that more than 50% of consumers stated that they received sufficient information on the costs of care from the doctor (73%) and at the hospital (59%). The focus groups revealed that there is an issue as to when this information is provided to consumers. This is interesting as the Health Professionals Council of South Africa (HPCSA) expects doctors to at least to reveal costs to patients as a component of ethical practise. There is some resentment reported about payments required over and above what schemes cover.

It seems that there is a common assumption that the private sector does provide better quality over the public sector. There is also a perception that quality varies within the private sector. Healthcare consumers would also value easy to understand accessible information about quality. At present, they rely on word-of-mouth information on what services to use from providers, family and schemes absent any objective criteria or data.

There is a general feeling from the discussions that there should be information available but in a simpler form (specifically regarding experience/details regarding doctors, people's experiences at hospitals, costs of services). Moreover, there is a sense that any information relating to all of this should be readily available (e.g. an app or online website like "Hippo" or "TripAdvisor" for private healthcare). There was a view that sharing of patient data between various providers that treat a patient would be beneficial. This is consistent with a sense that continuity of care is valued by patients and may also lead to better quality of care and lower costs.

A general recurring theme of this study was that, though many of the responses in the quantitative study yielded certain results, the discussion in the focus groups provided context and clarity. For instance, in some instances, it became clear that where consumers had responded to the survey indicating that they had sufficient information to make appropriate decisions, during the discussions it was clear that they either did not know the full extent of the information that was available or even how to process the information. This suggests that the consumers may not currently be best placed to fully understand the extent of the information that is available in the private healthcare sector or even how to process and understand it effectively. The results of this survey and focus groups discussion will be considered with the appropriate consideration of its limitations and in conjunction with other research and information that is relevant for the HMI's analysis.