

THE ROLE OF COMPETITION POLICY IN HEALTHCARE MARKETS

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ABSTRACT

Much has been said recently about the rising costs of healthcare in South Africa and the relationship that this phenomenon may have to competition law interventions in the sector, in particular the decision to abolish collective negotiation in 2004 and the relatively lax stance taken by the authorities towards the trend of ‘creeping mergers’ in the past decade. Furthermore there has been a suggestion from some quarters that competition is not working well in the different markets and that this is likely contributing to rising costs.

In this context, this paper seeks to understand the role that competition policy can and should play in healthcare markets. Drawing from international literature, we identify the ways in which competition policy can be used to ensure the effective functioning of healthcare markets. We then briefly describe the South African healthcare sector, highlighting some of the competition concerns which have been raised and consider what an effective role for competition policy in this context might be. Our findings suggest that the main areas of concern in the South African healthcare market will likely require both competition law and regulatory interventions to resolve.

¹ This paper is written in the personal capacities of the authors and does not necessarily reflect the views of the Competition Commission.

I. INTRODUCTION

Healthcare markets have been fraught with rising costs. Countries are challenged by limited financial resources at their disposal to increase healthcare output and efficiencies. Market imperfections and ultimately market failure means that these markets require careful regulation. Concerns over anti-competitive behaviour linger and are often labelled as a cause of rising prices. However, some commentators believe healthcare markets do not function like normal markets and hence should not be subjected to competition law principles.

Healthcare markets are complex as they are riddled with imperfect information, specifically asymmetric information. In many cases, the consumer (patient) is not price sensitive as the service (medical treatment) is either paid for by a medical scheme or by government. In these cases competition based on price is less relevant and quality becomes the significant competitive factor.² This can also be problematic, however.

Patients want to receive the best possible treatment, but have limited medical knowledge. The treatment is not homogeneous but differentiated based on individual needs. Patients play a passive role and are often uncertain of the service they are purchasing. They rely on doctors' expertise to direct them correctly along the healthcare supply chain. The large number of role players including medical schemes, general practitioners, specialists, hospitals, emergency services, pharmaceutical companies, medical consumables companies etc. adds to the complexity of this market.

An agency problem exists as the doctor sells an "expert service" by not only providing "medical care, or treatment, but also diagnosis and advice".³ The doctor can either recommend a cheaper or more expensive solution and could be influenced by options most profitable to him. Healthcare providers may buy unnecessarily expensive technology based on the money it can generate rather than the medical efficiency.

In the private sector, asymmetric information is present as medical schemes (insurers) have limited knowledge of the risk associated with new members. New members often lack full understanding of the nature of their insurance.⁴ Moral hazard arises as people may have the incentive to get medical insurance cover only when sick and end insurance once they have completed the treatment. Also patients could be tempted to consume unnecessary

² Gaynor, M. & Vogt, W. 'Antitrust and Competition in Healthcare Markets'. (2000) pg. 1414. Handbook of Health Economics, Volume 1 Edited by A.J Culyer and J.P. Newhouse. Elsevier Science B.V.

³ Gaynor, M. & Vogt, W. (2000) pg. 1416

⁴ Van den Heever, A. 'Review of Competition in the South African Health System' (2012)pg.8 Final Draft produced for the Competition Commission

quantities of healthcare goods and services if there are no limits to the amount of funding they receive for treatment.⁵ Health insurance providers attempt to combat these risks by not covering potentially risky applicants. They also implement waiting periods to new members and require patients to pay directly for certain services (out of pocket).

Competition in healthcare markets is also limited by significant barriers to entry. Potential entrants have to navigate the country's regulatory framework. It is costly to build new hospitals and medical facilities and install them with the latest technology. There is also a shortage of skilled medical practitioners. It is costly and takes time to train new medical professionals. The shortage of skills means that qualified professionals can charge increasingly higher fees for their services.

In this context, this paper seeks to understand the role that competition policy can and should play in healthcare markets. We briefly describe the South African healthcare sector and highlight some of the competition concerns. We then draw from international experiences to identify ways in which competition policy has been used to ensure the effective functioning of healthcare markets. Finally we then consider what an effective role for competition policy in this context in South Africa might be.

II. SOUTH AFRICAN HEALTHCARE SYSTEM AND CONCERNS FROM A COMPETITION POLICY PERSPECTIVE

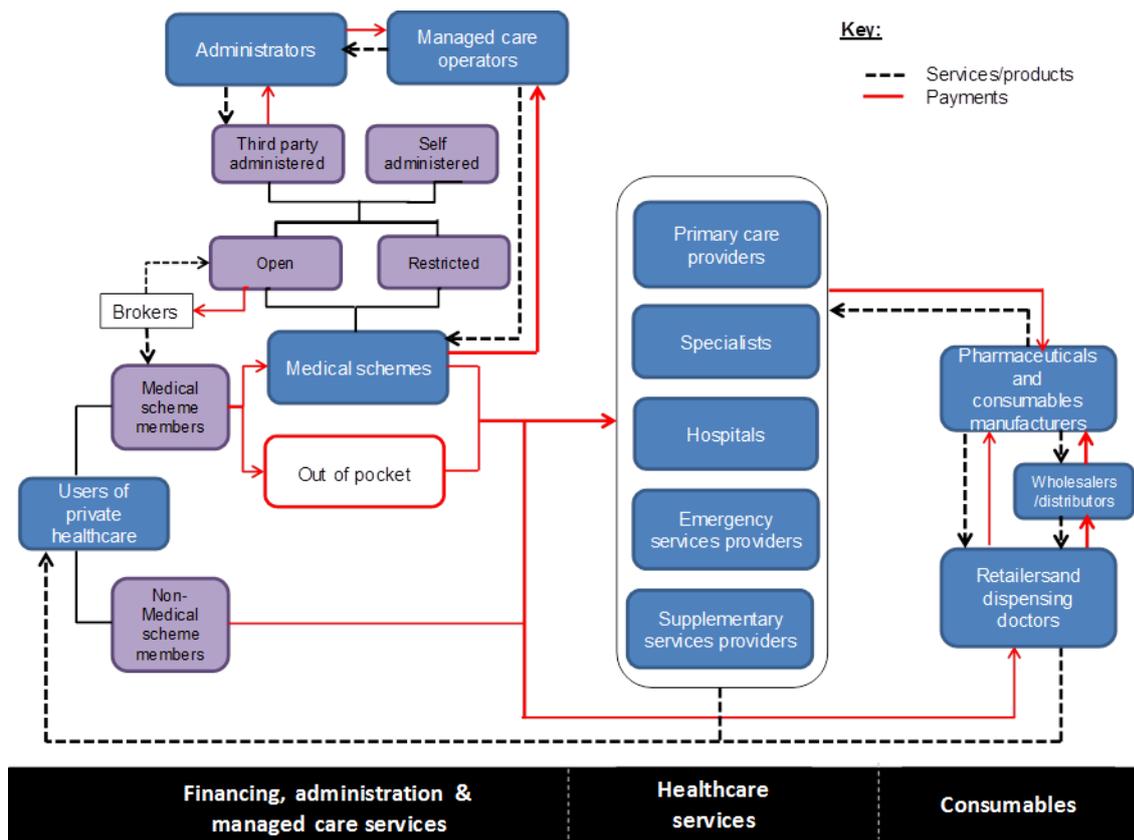
South Africa has a two-tiered healthcare system. The government funded public healthcare sector is overburdened and suffers from deteriorating conditions. The private health sector contains that portion of the healthcare services that are paid for by private patients themselves. This can be divided into those patients that make out of pocket payments and those that pay through a third party i.e. via medical aid schemes.

The South African private healthcare market can be broken down into the following sectors: (a) Healthcare providers, (b) Financing, administration and managed care services, (c) Consumables (as depicted in the diagram).⁶

Figure 1: The South African Private Healthcare Market

⁵ Van den Heever, A. (2012) pg. 8

⁶ Hodge, J. Fiandero, F. Lynch, S. Mohamed, R. 'Genesis Analytics Healthcare Background Paper' (2012) pg. 2 Commissioned by the Competition Commission.



Source: Genesis Analytics, 2012

Healthcare services include primary care providers, specialists, hospitals, emergency services and supplementary service providers.

Financing, administration and managed care services includes medical scheme administrators, the managed care providers, the medical schemes themselves as well as the brokers involved in marketing schemes and advising individual and corporate customers.

Consumables include pharmaceutical products and other medical consumables including their wholesale and retail distribution.

Patients in South Africa have free choice when selecting the services of a health practitioner. In the event of an individual from a household falling ill, 24 per cent⁷ consult private doctors. The GP then determines the path the patient should follow, which may include further testing, or referring the patient to a specialist or to a hospital. Healthcare practitioners therefore have an important “gatekeeper” role to play in guiding patients towards certain healthcare providers. The specialist in turn will direct the patient further

⁷ Hodge, J. et al (2012) pg. 45. HASA News June/July (2011) pg. 1. The figure is based on total households and not only households who use private healthcare.

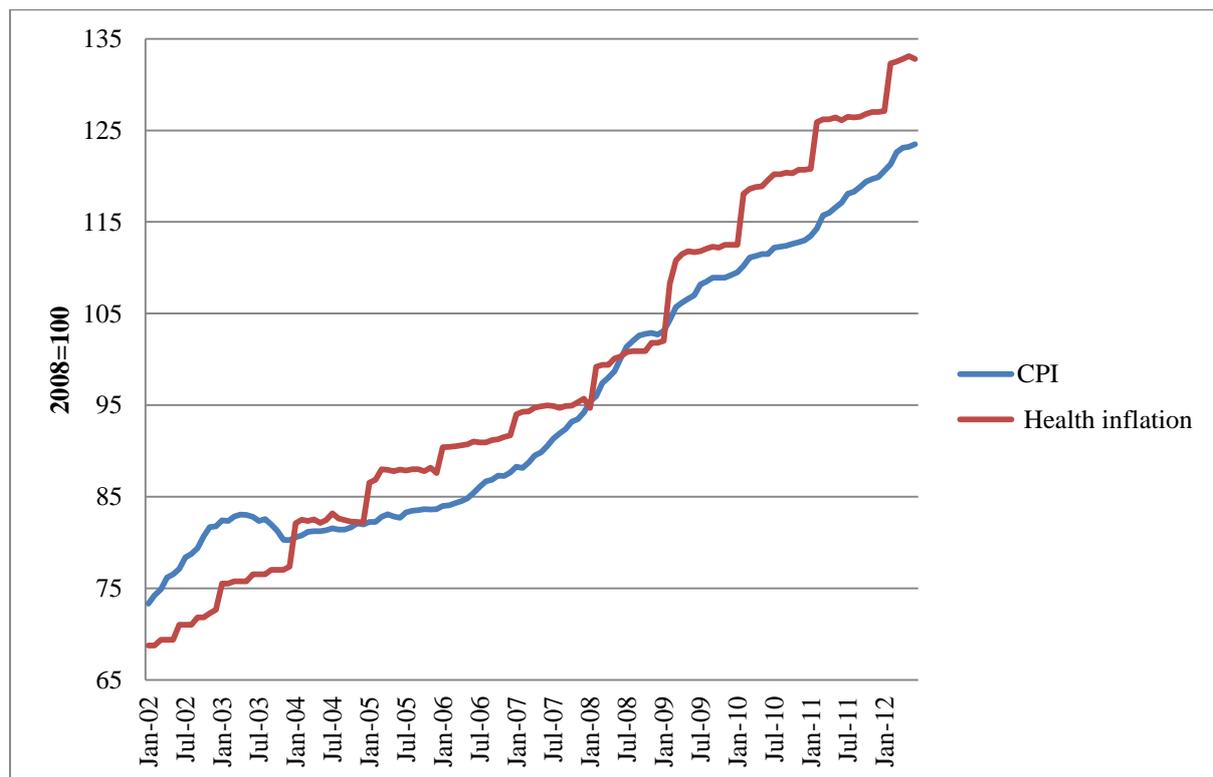
down the line of specialists and hospital treatment as needed. In many cases, patients will bypass the GP and make self-referrals, going directly to the specialist instead.

a) *Concerns over rising healthcare costs*

A recent PricewaterhouseCooper survey of medical schemes revealed that medical inflation is greater than the consumer price index (CPI) and that the average increase in medical aid tariffs was above the average increase in projected salary inflation.⁸ Given the poor state of the public hospitals, people will want to maintain the ability to go to private hospitals as long as possible. But as medical schemes become more unaffordable, some people may be forced to drop out and add to the burden of the public health system.

Based on Statistics South Africa figures, the graph below illustrates the quicker rate of growth in health inflation compared to CPI (2008=100).⁹

Figure 2: Health inflation and CPI in South Africa, 2002-2011



Source: Data from Statistics South Africa

⁸ PricewaterhouseCoopers 'Designing a Healthy Future' (2012) pg.13 <http://www.pwc.co.za/en/publications/medical-scheme-survey.jhtml> accessed on 10 August 2012

⁹ The base year is 2008. Figures used for 2002-2007 are health and CPI figures from 2000 that were reclassified to 2008 levels.

As early as 2008, the Minister of Health at the time Manto Tshabalala-Msimang, while briefing the Parliamentary Portfolio Committee on Health summarised the public concerns. She stated that although the Government's introduction of the Single Exit Price ("SEP") regulations has resulted in a reduction in medicine prices, the reduction did not result in overall healthcare savings for the patient. This, she thought, was largely due to increases in the tariffs of private hospitals, specialists and medical scheme administration.

Stakeholders from the different levels of the market, including the hospital groups, medical schemes and administrators, practitioners and regulators have attributed these increased costs to a number of factors including increased costs of technology, specialists, private hospitals and high administration fees. Some have even attributed these increases to the Commission's interventions in healthcare markets. The most notable of these interventions are the Commission's decisions regarding the *Hospital Association of South Africa*¹⁰, *South African Medical Association*,¹¹ and the *Board of Health Funders*,¹² which abolished collective bargaining and tariff negotiation by parties in the healthcare industry.

b) Role for Competition Law and Policy in Healthcare Markets

In the sections to follow we ascertain some of the key concerns that have been identified by different market participants in this on-going debate regarding increased healthcare costs and attempt to classify and extract those that fall within the ambit of the competition law and policy. We recognise that some of the market failures identified in the healthcare market do not necessarily fall within the jurisdiction of the Commission. Rather these concerns should be addressed through other means such as regulatory reform, the review of governance rules and changes in conduct by industry stakeholders.

It is important to understand the context and role of competition law and policy in healthcare. Some parties in the healthcare industry argue that healthcare should not be subjected to the principles of competition law and policy because it does not function like a normal (commodity) market. As stated above a key characteristic of this market is the information asymmetry that exists as the consumer of the services is ill-informed and is not in a position to shop around for the best services and prices offered. There is also moral hazard that exists and certain parties within the industry play a key agency role on behalf of the

¹⁰ Commission case number: 2002Aug164

¹¹ Commission case number:2002Aug165

¹² Commission case number:2002Aug166

consumers. As such the consumers require protection through regulatory intervention and cannot always be left to the operation of the principles of a free market.

While recognising that healthcare markets do not necessarily function as other normal markets it does not detract from the role for competition authorities alongside industry specific regulators.

As background to the role of the Commission it is important to note the legislative context under which it operates. Section 2 of the Competition Act states that its purpose is, inter alia, ‘to promote the efficiency, adaptability and development of the economy’¹³ ; and ‘to provide consumers with competitive prices and product choices’.¹⁴

Section 3(1) of the Act places economic activity in healthcare in the realm of competition scrutiny as it is stated in this section that the Act applies to all economic activity within, or having an effect within the Republic. Section 3(1) goes on to provide specific exceptions to the Commission’s jurisdiction, for example collective bargaining in terms of the Labour Relations Act (Act No. 66 of 1995). The Act also does not apply to concerted conduct designed to achieve a non-commercial socio-economic objective or similar purpose.¹⁵ It is noted that while at times there is some non-commercial activity that takes place in healthcare markets;¹⁶ this provision would not incorporate any and all activities of medical aid schemes, practitioners and other healthcare service providers. It is worth noting that the European competition law view is that it is the activities actually embarked on which are decisive and that *it is also not a condition that activities are carried on with a view of making a profit.*¹⁷

*Porter & Teisberg (2006) state:*¹⁸

‘Why is competition failing in health care? The reason is not the lack of competition, but the wrong kind of competition. Competition has taken place at wrong levels, and on wrong things. It has gravitated to a zero-sum competition, in which the gains of one system participant come at the expense of others. Participants compete to shift cost to another,

¹³ Section 2(a) of the Act

¹⁴ Section 2(b) of the Act

¹⁵ Section 3(1)(e) of the Act

¹⁶ For instance a scheme in terms of which a group of service providers agree to charge a minimal rate for one week for dental services provided to impoverished patients in a particular area.

¹⁷ The European Union and Sport: Legal and Policy Documents, by Robert Conrad Rudolf Siekmann, Janwillem Soek (2005)

¹⁸ M.E. Porter & E.O. Teisberg, Redefining Healthcare: Creating value-based competition on results. Harvard Business School Press (2006) pg. 4

accumulate bargaining power, and limit services. This kind of competition does not create value for patients, but erodes quality, fosters inefficiencies, creates excess capacity and drives up administration costs.'

From the above, it is clear that the interaction of the different market players at all levels is important to the operation of competition in the market. Competition authorities have a role to play in ensuring that where competition does exist, it functions effectively and for the benefit of consumers.

Below we will look at the role of different stakeholders in the healthcare market and identify some of the competition concerns.

A) Healthcare Service Providers

i) Primary Healthcare Providers

The importance of primary healthcare providers such as general practitioners (“GPs”) is that they are usually the first point of contact with the healthcare system. These providers are independent agents who work for themselves and they play a vital role in deriving demand and directing patients along the healthcare supply chain. In essence, they should act as gatekeepers that make necessary referrals to the right specialists; and direct the subsequent medical interventions required by a patient (e.g. further medical tests or prescription of consumables). It is perceived that the patients typically play a passive role in the process and follow their primary healthcare providers’ advice.

The prices of primary healthcare providers are not regulated. Industry associations (such as, recently, the HPCSA)¹⁹ or third parties (such as by firms like Healthman (Pty) Ltd)²⁰ compile reference price lists. These lists form the basis of practitioners pricing decisions. This trend has emerged since the demise of the National Reference Health Price List (“NHRPL”).

¹⁹ On 7 August 2012 the HPCSA announced the implementation of new Guideline Tariffs in terms of Section 53 of the Health Professions Act (Act No 56 of 1974) that is said to serve a dual purpose of protecting the public and guiding healthcare practitioners on the rendering of accounts in terms of prescribed ethical guidelines on informed content by ensuring their clients/ patients are fully informed about the cost of the potential service to be rendered

²⁰ Healthman is a privately owned healthcare consultancy for the management and administration of specialist, allied healthcare provider networks, group and individual practices and professional medical associations. Their areas of expertise include network administration, legal support, research, financial modelling and the development of tariff and code schedules. See www.healthman.co.za accessed on 12 August 2012

The HPCSA determines rules relating to how practitioners are to conduct themselves. These ethical rules²¹ relate to, inter alia, advertising and touting by healthcare providers,²² the employment of practitioners²³ and corporate involvement²⁴ in the industry.

In general the sector is viewed as having high levels of competition. It is also thought to have weak bargaining power vis-à-vis medical schemes as there are a large number of primary healthcare providers in the country who cannot collectively bargain with the medical schemes.

General concerns with primary care providers identified by the Commission and other stakeholders in the industry are the following:

- The HPCSA rules regarding advertising, employment etc. which restrict activities of practitioners are thought to prevent transparency and therefore competition in the market.
- Primary healthcare providers have also been criticised for not being effective gatekeepers for patients as they move along the healthcare supply chain. One problem is that patients are able to by-pass them and go directly to specialists and hospitals. This practice is blamed for rising costs because in these instances specialists charge more than GPs for a similar service.

Whilst affecting the extent to which competition can function effectively in this sector, these concerns are not directly the result of anti-competitive conduct which can be governed by the Competition Act. The relevant industry bodies and other role players, including the Department of Health have a role to play here in considering the effects of their rules and policies and introducing measures that can change the incentives of the key stakeholders to enhance competitive outcomes.

From a competition policy perspective the practitioners' current price setting process and use of reference price lists could be a concern as it could lead to coordinated pricing and therefore anti-competitive conduct. Providers argue that there is no credible tariff guideline

²¹ Ethical Rules applicable for its 12 professional boards,, published in Government Notice No R717 of 4 August 2006 and amendments thereto

²² Examples: Rule 2(2)- prohibits canvassing and touting, Rule 4 restricts information to be printed on professional stationary by registered practitioners

²³ Rule 18 restricts the employment of practitioners by non-approved practitioners

²⁴ Rule 8(4) restricts formation of certain forms of practice models; Rule 18 restricts the employment of practitioners by non-approved practitioners; Rule 23A restricts shareholding by practitioners in hospitals and other healthcare institutions; Rule 3(2) of Annexure 6- rule restricting the formation of partnerships and other juristic persons amongst practitioners.

and have alleged that some health providers (those with market power) have been able to unilaterally inflate prices. Further it has been argued that the reference price lists have to an extent provided some guidance to the market. While the removal of collective bargaining may have had unintended consequences in the market, this is not to say that this is or was the appropriate manner of determining prices from a competition policy perspective. There should be recognition that there are other market failures that exist which would require intervention from regulators.

ii) Specialists

Specialists have also been blamed for increases in healthcare costs, partly due to the amount of alleged healthcare expenditure that is attributable to this group. They play a pivotal role in driving demand, recommending treatment and directing patients along the healthcare supply chain, either through referrals, further testing, the prescription of consumables and the choice of hospitals.²⁵

It is often argued that specialists' high prices are a result of the shortage of specialised skills coupled with high demand for their services. Information asymmetries exacerbate this and consumers typically follow the advice of their primary healthcare providers without shopping around for better prices. Specialists therefore have little incentive to compete and can charge multiples of the reference prices. Due to this position enjoyed by the specialists, they may be seen as having market power.

Specialists largely operate as independent agents and are also subject to the HPCSA rules. Thus, hospitals cannot hire specialists directly. However specialists are closely linked to hospitals through either basing their offices in a specific hospital or through owning shares in the hospital. It has been suggested that elements of the relationship between hospitals and specialists may restrict competition.

In 2007 the Tribunal approved a merger between Phodiclinics (Pty) Ltd and the Protector Group of Hospitals. In its reasons the Tribunal called for a probe into the relationships between private hospitals and doctors, saying these were a major contribution to rising hospital costs. In particular, the Tribunal expressed concern that these relationships may drive up utilisation and hence costs of healthcare delivery. The Tribunal stated that:²⁶

²⁵ Hodge, J. et al (2012) pg. 23

²⁶ Tribunal case number 122/LM/Dec05 para 163

‘As long as specialists and hospitals are permitted to exist in an overlapping vertical relationship as they currently do, increased costs as a function of utilisation will continue to be a concern for the CMS, medical schemes and consumer.’

Since this matter, concerns have been raised by other stakeholders in the industry regarding the relationship between the hospital groups and specialists. They allege that there are perverse incentives offered by the hospital groups in order to attract and keep specialists within their hospitals.²⁷ It is also alleged that these perverse incentives result in over-servicing of patients and increasing private hospital costs.

The industry defines over-servicing as ‘the supply, provision, administration, use or prescription of any treatment or care (including diagnostic and other testing, medicines and medical devices) which is medically and clinically not indicated, unnecessary or inappropriate under the circumstances or which is not in accordance with the recognised treatment protocols and procedures, without due regard to both the financial and health interests of the patient.’²⁸

Examples of how potential perverse incentives are alleged to have taken place in this context include: specialists being given free rooms (or at very low rental) in hospitals and specialists being offered incentives for referring patients into hospitals. This conduct could result in over-servicing of patients and could also result in anti-competitive conduct such as the inducement not to deal with another hospital.

The HPCSA has specific guidelines prohibiting the offer and acceptance of perverse incentives. These guidelines limit the instances that a health professional may have a direct or indirect financial interest in hospitals and also speaks to the referral of patients by doctors to hospitals in which they have an interest in.²⁹ The HPCSA however does not have jurisdiction over entities not registered as health professionals such as the hospital groups, which limits the effect of the regulations.

These incentives are said to contribute to increased hospital costs as the hospitals pass the cost of incentives on to the patient through higher tariffs. Furthermore competition is potentially reduced as consumers may lose the benefit of practitioners who practice at more

²⁷ It is noted that there is a general sentiment that hospitals want to have specialists operating from their hospitals as this works to attract patients to the hospital and specialists would also be more likely to refer to patients to the hospital in which he/she operates.

²⁸ The medical and Dental Board (HPCSA) (2002), Guidelines for Good Practice in Medicine, Dentistry and the Medical Sciences: Policy Statement on Perverse Incentive, Booklet 7.

²⁹ See Rule 23A and 24 of the HPCSA Ethical Rules as applicable for all its 12 professional boards, published in Government Notice no R717 of 4 August 2006 and the amendments thereto

than one hospital. These perverse incentives discussed above may give rise to competition concerns where, for instance, the provision of incentives by a dominant firm has an exclusionary effect on other market participants with no pro-competitive gains arising from such conduct.

The concerns regarding specialists are summarised as follows:

- The degree of market power held by specialists and their ability to charge very high rates - on some occasions several multiples of reference prices.
- The nature of the relationship between specialists and hospitals.

Once again, however, there is also a role for the various industry bodies in considering the impact of their rules on the effectiveness of competition in the industry.

iii) Private Hospitals

This is an important sector accounting for roughly 36 per cent of total healthcare expenditure.³⁰ The market is concentrated with Netcare, Life Healthcare and Medi-Clinic being the three largest players, collectively holding approximately 80 per cent of the market with independent hospitals (mostly represented through the National Hospital Network, (NHN) constituting the remainder of the market.³¹ Concentration in the market is increasing as the three large hospitals gradually acquire independent hospitals.

Hospitals are not subject to price regulations (aside from the regulations which apply to the pricing of pharmaceutical products). However the high degree of concentration provides hospitals with strong negotiating power over the medical schemes. The NHN was founded in 1996 with the role of 'coordinating and providing resources to its members so as to assist them, particularly in achieving efficient and effectively managed patient servicing and input costs that are competitive in the marketplace'.³² Through an exemption granted to the NHN by the Commission,³³ the NHN negotiates tariffs on behalf of its members with the

³⁰ Hodge, J. et al (2012) pg. 23. HASA Briefing note to Portfolio Committee (27 July 2011), Submission to Parliament.

³¹ Hospital Association of South Africa (HASA) (2007) 'Overview of the private hospital industry in South Africa.'

³² See NHN website: www.nhn.co.za

³³ See Government Gazette, 15 June 2006 No. 28924 Notice 775 of 2006.

medical schemes or their administrators. The three hospital groups negotiate tariffs independently.

Evidence heard before the Tribunal in several healthcare matters reveals that the hospital groups deny the link between the gradual, systematic increase in private hospital concentration and the rising costs of healthcare. In *Netcare / CHG*³⁴ and other mergers the Tribunal acknowledged the ‘creeping mergers’ phenomenon where a single acquisition, considered on its own merits does not result in a substantial lessening of competition, but where a series of these systematic or ‘incremental’ transactions occurring over a period of time have the collective result of increasing the market power of the acquiring firm. Traditionally the increase of concentration and market power often leads to anti-competitive outcomes, such as increased prices, reduced output and it increases the risk of collusive conduct amongst the fewer market players.

Concerns within the hospital sector are:

- As discussed above, perverse incentives are a concern. It has been alleged to the Commission that the hospitals put incentives in place for the doctors to meet specific targets. This would incentivise doctors to push patients through a particular hospital, regardless of cost or quality. In some instances GPs and specialists own shares in the hospital giving them indirect incentives to utilise these facilities. Whilst concerning, this is an issue of governance rather than competition policy.
- There are concerns relating to hospitals relationships with specialists. Hospitals are alleged to invest heavily in technology and top facilities to attract specialists. Some refer to this process as the medical arms race and blame it for the upward pressure on prices. This may be a manifestation of specialists bargaining power (as a result of the current shortages) and the bargaining power vis-à-vis funders said to be held by the hospitals. The hospitals would not over-invest to such an extent if they were not confident of their ability to recoup these investments through high prices and as such, this behaviour is largely a manifestation of their high market power.
- The sector is subject to high barriers to entry due to high costs arising from the purchase of expensive medical equipment and the costs of constructing a facility. The problem is further exacerbated by a shortage of medical staff that is directly hired by

³⁴ Netcare hospitals Group (Pty) Ltd/ Community Hospital Group (Pty) Ltd. Tribunal Case no. 68LMAug06

the hospitals (nurses) and those who use the hospital facilities (specialists). In addition, hospitals require licences from the Department of Health. This is perceived to be a lengthy process and in recent matters before the Commission, questions have arisen regarding the manner in which these licences are issued to prospective entrants.³⁵

- The levels of concentration and the geographic distribution of the three main hospital groups combined with the perceived high hospital prices seems to suggest that there may be issues of regional or local dominance that is enjoyed by the hospital groups.
- Since there is no price regulation for hospitals, tariffs are negotiated between the hospital groups and medical schemes. There is a concern that the high degree of concentration provides hospitals with strong negotiating power.
- Joint ownership by three groups into smaller independent hospitals. The trend is that where there is joint control of independent hospitals, the groups take over the management of the independents, including the negotiation of tariffs and DSP arrangements, resulting in independents implementing the group's tariffs. This could result in collusive behaviour and dampened competition between the groups and the independents.

B) Healthcare Funders

i) Medical schemes and administrators

People wishing to use private medical treatment will, for the most part, take out medical insurance to cover the costs. The main source of legislation regulating the private healthcare insurance sector is the Medical Schemes Act, No. 131 of 1998. The South African healthcare sector is comprised of both open and closed medical schemes. The largest of these medical schemes is by far Discovery Health Medical Scheme, which is an open scheme. Another scheme which has grown exponentially over the years is GEMS which is restricted to government employees, and is today the second largest scheme.³⁶

³⁵ Allegations before the Commission are with regard to the major hospital groups acquiring and / or making use of smaller independent players to apply for and acquire hospital licences, which in effect will be used for the hospital groups by acquisition of the independent player who is in possession of a licence. This has however not been investigated by the Commission at this stage.

³⁶ Stern, Medical Aid Funding, Sic code 82130 (May 2012) pg. 1. The Council for Medical Schemes (CMS) Annual Report for 2010-2011 reports that there were 100 medical schemes at the end of 2010. Of these, 27 were open and 73 closed.

In both open and restricted medical schemes, third-party administrators compete to provide administrative services, and in return, the administrator is remunerated from the contributions paid into the scheme.³⁷ Medical administrators negotiate tariffs directly with the rest of the healthcare system and therefore play a pivotal role in finding ways to reduce costs.

*Bisseker (2003)*³⁸ explains the relationship between medical schemes and administrators as follows:

‘Medical schemes are mutual funds, not-for-profit entities managed by boards of trustees. Any surplus of contributions over payouts is retained in the scheme each year to build its reserves, which belong to the scheme’s members. Medical aid administrators and managed care organisations are the for-profit companies that are contracted by schemes to manage risk on their behalf.’

The Competition Tribunal in the *Momentum / African Life Health* merger stated that, “medical scheme administrators do not have carte blanche to set prices, since the Registrar for Medical Schemes monitors fees and regulates the relationships between the schemes and the administrators.”³⁹ However, the rising healthcare costs have also been attributed to the administrators. Recently the Discovery Health Medical Scheme members called for an independent review into the R3.2bn administration and managed care fees it paid its administrator Discovery Health during the 2011 financial year.⁴⁰ The rate administrators charge is not regulated.

Other conduct of the medical schemes and administrators raises concerns. It is notable that increasingly the distinction between (non-profit) medical schemes and (for-profit) medical administrators has become more superficial. In some cases, medical schemes tend to act commercially to attract members. In this scenario, the interests of the members of the scheme may not always be taken care of or made a priority. It has also been alleged to the Commission that brokers are being given incentives by medical schemes to attract members. This will hamper their ability to play an advisory role of bridging the information asymmetry.

³⁷ Hodge, J. et al (2012) pg. 82.

³⁸ C. Bisseker (2003). Healthcare debate: *For-Profit Schemes could eliminate inefficiencies but may undermine government’s objectives*

³⁹ Tribunal Ruling Momentum Group Limited and African Life Health Case No. 87/LM/Sep05.

⁴⁰ Kahn, T. ‘Member activism a sign of things to come’ Business Day 13 July 2012

It raises competition concerns as members are channelled to a scheme based on the relationship between the scheme and the brokers, and not on competitive factors.

It is noted that medical schemes to a large extent play (or should play) an agent role on behalf of the consumer. Being the primary purchaser of healthcare services on behalf of its members, a medical scheme should have the interests of the consumer at heart. It is important that these incentives to keep costs low are effectively passed on from the scheme to the administrator.

Some stakeholders believe that medical schemes are unable to act in the interest of their members due to the lack of bargaining power. They argue that the Commission's decisions (BHF, HASA, and SAMA) in 2004 led to the medical schemes' inability to control rising healthcare costs as a result of this imbalance in bargaining power with the hospitals. The change from collective negotiation to individual negotiations shifted the balance of power to the (concentrated) hospital groups. They allege that hospital groups abuse their power against the medical schemes through threatening conduct such as the threat of balance billing.⁴¹ With this threat it is said that medical schemes would have the short-end of the negotiations as balance billing would have a serious impact on its member and with this fear of losing members the medical scheme would then, in most cases, agree to tariffs proposed by the hospitals.

Localised market power due to the geographical distribution of the hospitals of the three main groups may also increase their bargaining power due to the necessity for the schemes of having comprehensive geographical coverage.

However, the hospital groups have argued in cases before the Tribunal that medical schemes have countervailing power. The increased consolidation of medical schemes is said to have increased the bargaining power they hold.

With regard to role of the Commission's decision in contributing to this situation, we are of the view that this cannot be seen as the only factor which has led to the increase in healthcare costs. The Commission's position has always been informed by legislation and the realisation that the collective negotiation created a platform for collusion which itself leads to varying anti-competitive effects to the detriment of consumers. However, it is important to understand that in a "second best" world, normally sound interventions can have unintended consequences. With this in mind, a healthcare inquiry could seek to better understand the

⁴¹ Balance billing refers to a situation whereby healthcare providers or hospitals bill patients directly for care above what the insurer pays

dynamics at play in these negotiations. Ultimately, however, the solution to the issue is likely to involve some form of government or regulatory intervention.

Again, whilst these problems have an impact on competition, they do not all fall within the realm of competition policy to solve. There are essentially governance issues which need to be addressed by the relevant industry bodies and the Department of Health.

ii) Managed care and Designated Service Providers

Prior to a patient being hospitalised, the medical scheme or its managed care organisation performs a pre-authorisation process. The process is designed to monitor appropriateness, promote efficacy, quality and cost effectiveness of the delivery of relevant health services.⁴² It analyses the use of new technology, equipment, drugs or other consumables. There is continuous case management by the scheme or managed care organisation to limit or narrow its exposure to costs.

There are various risk sharing mechanisms including selective contracting, capitation agreements and alternative reimbursement models. These arrangements typically require that an element of the medical scheme's risk is transferred to an intermediary or healthcare provider and can assist significantly with lowering costs. Managed care is provided by different players, usually known as managed care operators ("MCOs"). All MCOs are legally obliged to operate through contracts with medical schemes and require authorisation by the CMS through an accreditation process.⁴³

In certain instances patients are directed by their funders to specific providers who form part of a preferred provider network ("PPN") (or DSP). Here medical scheme members forego their freedom of choice of healthcare provider in exchange for lower prices. PPNs exist across the various healthcare levels, i.e. GP networks, specialist networks, pharmacist networks. The PPNs form an important tool to manage healthcare costs and risks to the fund. The medical schemes or their administrators conclude PPN agreements with healthcare providers where the providers offer cheaper services in exchange for greater volumes of patients.

Providers are meant to compete on cost and effectiveness to be included in these networks. The ability of these arrangements to offer low prices depends on the availability of good, well-placed competing providers and the ability of the medical schemes to add and

⁴² Section 1(1) of the Medical Schemes Act 131 of 1998

⁴³ Hodge, J. et al. (2012) pg. 58

remove hospitals. These factors are meant to ensure both current and would-be network hospitals offer cost-effective and quality care. The credibility of the threat of removal from the network would depend on the availability of acceptable alternatives and could reduce the providers' bargaining power and price.

The growth of Discovery's Keycare Plan is illustrative of the way in which the medical scheme and hospital market has introduced a successful network arrangement. However, it is one of very few such examples.

In the South African context managed care as discussed has not been as effective as it could be perhaps due to the fact that it has not been fully explored. Where there has been some use of managed care, the efficiencies claimed to result from such arrangements (e.g. lowering costs) have been disputed by parties in the industry. Managed care is also affected by the relationships and incentives between medical schemes and scheme administrators as discussed above.

General concerns on PPN arrangements:

- The increased hospital concentration means that there are fewer alternatives for medical schemes to enter into these arrangements with. It may place medical schemes in an undesirable situation when they attempt to negotiate for lower prices with hospitals.
- The joint ownership in independent hospitals by the major hospital groups may have the same effect as concentration as the major hospital groups negotiate PPN arrangements on behalf of the independents in which they have shareholding.
- Regional dominance and market power of providers places medical schemes in a precarious position when negotiating PPNs. This could lead to a situation where a certain hospital (independent or part of a group) may be excluded in a region due to the fact that another hospital group has more presence and may be able to offer the scheme a better network in that region. In this case the hospital group may be selected not on its competitive offering but due to its market power in the region.

For the Commission, a concern also arises over the manner in which PPN arrangements are entered into. The exclusive nature of these arrangements means that providers who are not part of these arrangements will (technically) not be able to offer

services to members of the schemes that have entered into an arrangement.⁴⁴ Such arrangements are normally assessed under the rule of reason provisions of the Act, thus giving allowance for efficiency justifications to be considered. The competition authorities will have to determine whether the stated efficiencies outweigh any anti-competitive effects that may result from these arrangements.

C) Consumables

Pharmaceuticals can be administered to a patient in hospital or dispensed for use out of hospital. When purchasing pharmaceuticals from retail pharmacies or dispensing doctors, they are usually either paid for by the user through the medical scheme or through self-funding. There is no concentration in the market due to the high presence of domestic and international competitors. Moreover, the sector has grown more competitive with lower prices due to the onset of legislation giving large corporates such as Clicks and Dischem the right to own pharmacies. The pharmaceutical industry is considered to be one that does not have a significant level of concentration due to the significant number of manufacturers, wholesalers and retailers, as well as the significant number of imports in the market.

III. INTERNATIONAL EXPERIENCE OF COMPETITION POLICY INTERVENTIONS IN HEALTHCARE MARKETS

The OECD has reported that healthcare costs have been rising on a sustained basis for over 30 years in Europe, Canada and the US.⁴⁵ Governments are increasingly looking to competition policy as a way of bringing about market efficiencies to combat rising prices and improve quality. The role for competition policy varies considerably per country and is influenced by the country's stage of development. Developing country governments tend to focus on increasing access to primary healthcare rather than ensuring that the existing markets function competitively and efficiently. As a result, competition policy has played a limited role in these healthcare markets.⁴⁶

Individual countries' approaches to competition in healthcare are also influenced by the role of government and type of funding. In many cases fiscal constraints limit

⁴⁴ Apart from a handful of members and patients paying out-of-pocket

⁴⁵ OECD, 'Health at a Glance 2011: OECD Indicators' (2011). OECD Publishing, Paris France

⁴⁶ Van den Heever, (2012) pg. 18

governments' ability to fully fund a public healthcare system. Instead pressure on the public health system is eased through market- based and private sector funding and service provisions that cover a portion of the population. These multi-tiered healthcare systems consist of a mix of social, employer-based, industry- based and out of pocket systems.⁴⁷ The amount of private expenditure as a percentage of total healthcare varies per country and in some cases this portion can be significant. The WHO lists India's private expenditure at 71 per cent, South Africa 56 per cent, Brazil 53 per cent, while in Europe it is much lower with Germany 23 per cent, Netherlands 14 per cent and the UK 16 per cent.

Internationally, the most common competition policy interventions tend to be through merger control, although in many ways these opportunities to intervene do not arise from the authority's own doing, as they would through enforcement actions initiated by the authority. But competition authorities have also prosecuted cases of abuse of dominance and price fixing.

(a) Changes in Legislation

The South African healthcare market is vastly different to the other, mostly developed, countries that have successfully introduced legislation to stimulate competition in their healthcare market. But there are still useful lessons for South Africa to learn from other country experiences.

Both the Netherlands and Germany have introduced a system of managed competition in their healthcare markets. Both countries rely on competing insurance plans. All citizens are required to purchase a health insurance package from one of the competing private insurers. The Netherlands Health Care Authority (NZA) manages competition between insurers and sets budgets for most healthcare providers.⁴⁸ In Germany the Statutory Insurance System (SHI) provides universal coverage through their system of competing health insurers, called sickness funds.⁴⁹ These funds compete on price for the enrolment of citizens as members. About 90 per cent of the population is covered by the SHI while the remainder use private health insurance. Both countries coordinate payment policies through a multi-payer system. In Germany, payment is largely determined by "all-payer negotiations each year, while in Netherlands cohesion is achieved through a set of shared payment policies with negotiations

⁴⁷ Van den Heever, (2012) pg. 18

⁴⁸ Schoen, C. Helms, D. Folsom, A. 'Harnessing Health Care Markets for the Public Interest for US Health Reform from the German and Dutch Multi-payer Systems' (2009) pg. 15 The Commonwealth Fund.

⁴⁹ Schoen, C. et al. (2009) pg. 6

at the margins.”⁵⁰ While insurance companies negotiate collectively, this process is transparent where various stakeholders, including government, participate.

Both the Netherlands and Germany have taken steps to increase transparency and access to information to ensure the effective competition in the healthcare market. The NZa attempts to address information asymmetry by improving transparency on the quality of service provision. It has the mandate to retrieve and publish information from healthcare providers which allows patients to make informed decisions on hospitals. It has even developed a public website that provides details of quality of service. The German Institute for Quality and Efficiency in Healthcare is an independent institute that undertakes comparative assessments and makes recommendations on quality. It provides an independent source of information for clinicians and patients.⁵¹

Some commentators argue that increasing patients’ access to information would not be successful in increasing competition as patients do not necessarily have the time or capacity to research the information required to make an informed decision. But if information is available then other agents, such as GPs, could act on the patients’ behalf (as long as they have the patients’ best interest at heart). Or alternatively a third party such as a medical insurer with sufficient information would be able to steer the patient correctly. If health insurers had sufficient bargaining power they could encourage healthcare providers to improve quality and price if the providers want to be on the insurers’ recommended list. In addition, if enough people have access to information on quality and price of healthcare provider, then the provider would not be able to discriminate between well informed and poorly informed customers and would have to assume they are all well informed.⁵²

The English National Health Service (NHS) introduced several market-based reforms aimed at increasing choice and provider competition between 2002 and 2008.⁵³ Following these reforms, the UK has established the Cooperation and Competition panel (CCP) agency to oversee competition in the NHS. The NHS reforms include a new hospital reimbursement system that gives public hospitals greater fiscal and managerial autonomy. Although NHS hospitals are publically owned, there are incentives for hospitals to compete on quality. Hospitals compete in geographical markets because patients typically prefer to be treated

⁵⁰ Schoen, C. et al. (2009) pg. 6

⁵¹ Schoen, C. et al. (2009) pg.11

⁵² Gaynor, M. ‘Competition in Hospital Services’ (2012) pg.7 OECD Working Paper on Competition and Regulation 2.

⁵³ Cooper, Z. Gibbons, S. Jones, S. McGuire, A. ‘Does Hospital Competition Save Lives? Evidence from The English NHS Patient Choice Reforms’ (2011) 121 *The Economic Journal* pp 228-260.

closer to home.⁵⁴ Research done by *Gaynor and Propper (2010)* found that hospitals in areas where patients had a bigger choice of hospitals had higher clinical quality (measured by lower death rates following admission and shorter stays in hospital) without seeing an increase in total operating costs. A key point from the NHS experience is that if reforms that seek to stimulate competition in healthcare are to be effective, then patients need to be interested in making choices and have alternative providers they can access. Patients must therefore be responsive to quality signals. This in turn means that they, or someone advising them, must have access to information on the quality of the service being provided.

The South African healthcare market is not transparent. While South Africa has very different challenges to those in Netherlands, the UK and Germany, these countries' examples of increasing access to information could provide a useful insight. For example a healthcare inquiry could look at the impact of the rules against advertising.

There has also been an emergence of private hospital and insurance markets in the UK. The balance of power between private hospitals and insurance providers is mixed. Private hospitals are dependent on large private medical insurers (PMIs) for patients. But private hospitals may actually have a degree of market power over PMIs where there are limited numbers of private hospitals or they are in "must have" areas.⁵⁵ This conflicting relationship between private hospitals and medical insurers seems to also be present in South Africa where the medical schemes wishing to offer nationwide coverage are at the mercy of the highly concentrated large hospital groups.

Columbia was the first low income country to introduce a form of managed competition into its healthcare market in 1993 with Law 100. In this system, the health insurers compete for enrolment of the population. There are two types of schemes: the contributory regime for those with formal employment and are able to pay (financed through mandatory contributions) and the subsidised regime for those that are unable to pay (subsidised by the contributory regime and taxes).⁵⁶

While many commentators look to the success of these reforms, there have been many challenges. A study undertaken by *Vargas et al (2010)* revealed various design flaws in the system. In some instances, out of pocket payments are too high and provide a barrier to access to healthcare. The process of authorising treatment causes delays and patients often

⁵⁴ Gaynor, M., Propper, C. 'Healthcare competition saves lives' <http://www.voxeu.org/article/healthcare-competition-saves-lives> accessed on 11 July 2012.

⁵⁵ Office of Fair Trading. 'Private Healthcare Market Study: Report on the market study and proposed decision to make a market investigation reference' (2011) pg.95

⁵⁶ Vargas, I., Vazquez, M.L., Mogollon-Perez, A.S. & Unger, J. 'Barriers of Access to Care in a Managed Competition Model: Lessons from Columbia' (2010) pg.1. BMC Health Services Research

end up having to go between different healthcare providers for the complete treatment.⁵⁷ Most concerning is that the study found that competition triggered a change in some public hospitals as they appear to prioritise economic profit over patient healthcare.⁵⁸ They are believed to focus on patients with profitable illnesses that are easily treatable with short stays in hospitals. Patients that are uninsured or have lost documents are denied treatment. Some complain that under the old system, they would still have received treatment. The Columbian example provides good insight into the challenges facing a developing country that tries to introduce competition into healthcare while attempting to provide universal coverage and the perverse incentives which can be created if care is not taken. South Africa, with its two tiered health system risks facing similar challenges.

India has taken a slightly different approach to stimulating competition in its healthcare market. There is a strong demand for medical equipment, not all of which can be manufactured locally in India or by Indian companies. International companies are setting up manufacturing plants to assemble high value medical equipment while local firms focus on consumables and disposable equipment. In order to stimulate competition among international firms entering the local market, the Indian government lowered import duties on medical equipment and introduced other tax incentives.⁵⁹ While this is not a wholesale change in legislation to promote competition it illustrates how simple changes could lower the cost of upstream products that could contribute towards easing pressure on healthcare costs. This provides an interesting example of how a developing country has sought to stimulate competition in a part of their healthcare market and perhaps there is a possibility for South Africa to introduce a medical angle into its Industrial Policy Action Plan.

(b) Hospital mergers

Despite the many unique instances of competition policy interventions described above, the involvement of competition authorities in healthcare markets is mostly through hospital mergers (as has been the case for South Africa). In some instances hospital mergers can lead to greater efficiencies through the creation of economies of scale. Larger hospital centres can provide a wider mix of technology and services and thus increase the quality and

⁵⁷ Vargas, I. et al, (2010) pg.7

⁵⁸ Vargas, I. et al. (2010) pg.7

⁵⁹ PricewaterhouseCoopers 'Healthcare in India: Emerging Market Report' (2007) pg.18 http://www.pwc.com/en_GX/gx/healthcare/pdf/emerging-market-report-hc-in-india.pdf accessed on 30 July 2012

quantity of hospital services. However it is unlikely that these savings are passed onto the consumer. Increased market power could also lead to increased prices and decreased quality to the detriment of the patient. Many European countries including France, Germany, Netherlands, Sweden and the UK have thus taken steps to introduce stronger market mechanisms for hospital services.⁶⁰

The US healthcare market has experienced a significant degree of consolidation with an increase in mergers and acquisitions involving insurers, hospitals, and doctors. There were over 900 hospital mergers between 1995 and 2002. The Federal Trade Commission and Department of Justice challenged only 7 of these cases in court but lost all of them.⁶¹ These competition authorities have since had some success. In 2005, they challenged a hospital merger ex-post, and unlike previous cases, the court accepted their approach to defining the relevant limited geographic market.⁶² Retrospective studies have revealed that concentration tended to lead to higher prices and by nontrivial amounts.⁶³ A study on Medicare patients in the US found that greater market concentration led to a drop in quality measured by increased mortality levels. However results from studies on the impact that mergers have on hospital quality for privately insured patients are more mixed.⁶⁴

Similarly, the Dutch Competition Authorities (NMa) approved several hospital mergers between 1998 and 2003 during a period in which price and supply regulation prevented competition. Following this period, the Dutch gradually introduced competition in their hospital markets and by 2005 hospitals were able to compete on price.⁶⁵ The NMa have also done retrospective studies by assessing 6 hospital mergers. They found that 6 of the 12 hospitals increased their prices significantly while only three saw a decline in price. Kemp et al list several explanations for the price increases including an “increase in market power, a relative improvement of quality, increased costs, improved negotiation skills and administrative choices in allocating the total budget”.⁶⁶

A similar retrospective study on hospital mergers in South Africa could be beneficial as it could provide a broader picture of the impact of creeping mergers. It could also determine whether past mergers have in fact strengthened the bargaining power of hospitals

⁶⁰ OECD ‘Competition in the Provision of hospital Services:2005’ (2006)pg.9 Directorate for Financial and Enterprise Affairs, Competition Committee

⁶¹ Kemp, R. Kersten, N. Severijnen, A. ‘Price Effects of Dutch Hospital Mergers: An Ex-post Assessment of Hip Surgery’ *De Economist* Volume 160, Number 3(2012) pg 237-255

⁶² Kemp, R. et al. (2012) pg.2

⁶³ Gaynor, M. (2012) pg.13

⁶⁴ Gaynor, M. (2012) pgs.10-11

⁶⁵ Kemp, R. et al. (2012) pg.5

⁶⁶ Kemp, R. et al. (2012) pg.16

as medical schemes claim. The medical schemes argue their bargaining power has weakened because, if they want universal coverage, they have to negotiate with the dominant hospital groups with hospitals in ‘must have’ areas (as discussed in the English example). All of this information will assist the Competition Commission in analysing future hospital merger cases.

(c) Abuse of Dominance

While competition authorities have mostly dealt with hospital mergers, there have also been some notable enforcement matters in this area. In January 2012 the Italian Antitrust Authority (IAA) found against Pfizer Inc. and its Swedish and Italian subsidiaries on an abuse of dominance case in their pharmaceutical market. The IAA found that they “jointly engaged in unlawful exclusionary conducts so as to unlawfully extend intellectual property exclusive rights over Pfizer’s Xalatan drug, deterring or, in any event, delaying entry of generic competition on the Italian market”.⁶⁷ Pfizer was fined \$11 million but the firm has subsequently appealed the matter.⁶⁸

(d) Price fixing

The Commission’s ruling on tariff negotiations as discussed above attempts to prevent price fixing within the healthcare market. Concern does seem to have been warranted, as there are several cases of other countries breaking up cartels in their healthcare markets.

In 2010, the Competition Commission of Singapore found that medical tariff guidelines set by the Singapore Medical Authority (SMA), partly at the behest of the Department of Health, were anti-competitive.⁶⁹ The CCS argued that such guidelines create a ‘clustering effect’, whereby providers of medical services lose the incentive to charge below the guideline even in instances where they are able to do so. This ruling came after the SMA voluntarily ceased publishing the guidelines in 2007, after it had received advice that this might amount to anti-competitive conduct, thus allowing for an ex-post evaluation. A study

⁶⁷ Ansaldo, P. Grassani, S.. ‘From Astra-Aeneca to Pfizer: When Protection of Originators’ Patents Ceases to be a “Right” and Becomes an Abuse of Dominance’ (2012)pg.2 CPI Antitrust Chronicle

⁶⁸ Ansaldo, P. & Grassani, S. (2012) pg.2

⁶⁹ Health Policy Monitor http://www.hpm.org/de/Surveys/University_of_Singapore_-_Singapur/16/Medical_fee_guidelines_anti-competitive.html Accessed 20/08/2012

conducted by CCS has shown that fees for medical services have fallen since 2007. Complaints of over-charging by doctors received by the SMA have also declined.

The Mexican Federal Competition Commission has investigated several cases of collusion in the form of bid rigging in their healthcare market (particularly in the market for pharmaceutical products) where the effects, particularly on the poor, have been substantial. The Mexican Institute of Social Security (IMSS) (the largest purchaser of pharmaceutical products and other medical supplies) signed a memorandum of understanding with the OECD in 2011 agreeing to work with the OECD to adopt international best practice for fighting bid rigging).⁷⁰

The Competition Commission of Pakistan (CCP) recently found 20 medical centres and 5 of their administrative offices guilty of market allocation and price fixing. Pakistanis wishing to immigrate to Gulf countries need to undergo a pre-departure medical test at a Gulf Cooperation Council approved medical centre. The Pakistani administrators and medical centres were found guilty of allocating patients and jointly fixing the price of these medical tests. They were fined a total of 450 million rupees (€3.9million).⁷¹

In 2010, the High Court in Auckland imposed fines totalling NZ\$100 000 on two Waikato pathology service providers who admitted to agreeing not to compete, pending a proposed merger. Both the New Zealand Diagnostic Group and Pathology Associates Limited admitted wrong doing and cooperated with the Commission.⁷²

IV. A POSSIBLE REVIEW OF THE SOUTH AFRICAN HEALTHCARE MARKET

As illustrated above, there is clear evidence that the South African healthcare market is not operating efficiently. Rising healthcare costs are making private healthcare unaffordable for more people. This could put additional strain on the already overburdened public healthcare sector. While this market is unique, it is not sufficiently different to justify its exclusion from competition law intervention. Therefore it should be subject to competition scrutiny to protect patients from potentially harmful anti-competitive conduct. Regulatory

⁷⁰ Gurria, A. 'Fighting Against Bid Rigging: OECD-CFC-IMSS Cooperation' (2011) from OECD www.oecd.org/mexico/fightingagainstbidriggingoecd-cfc-imssco-operation.htm on accessed on 1 August 2012

⁷¹ Samadi, F.. 'CCP shuts down medical cartel' Global Competition Review <http://www.globalcompetitionreview.com/news/article/32136/ccp-shuts-down-medical-cartel/> accessed on 30 July 2012

⁷² Commerce Commission New Zealand '\$100 000 penalties imposed in Waikato pathology services case' <http://www.comcom.govt.nz/business-competition-media-releases/detail/2010/100-000-penalties-imposed-in-waikato-pathology-services-case> accessed on 1 August 2012

intervention particularly when it comes to governance concerns is also necessary to address market imperfections not accommodated through competition policy.

There has already been much discussion in the press about a potential Commission market inquiry. *PricewaterhouseCoopers (2012)* published the results of a survey of 20 South African medical schemes representing 53 per cent of the industry. It revealed that 57 per cent of the respondents thought a Commission investigation into healthcare costs would be useful and 38 per cent thought it was long overdue.

A market inquiry would require input and cooperation from several stakeholders including the Department of Health and industry bodies. It could form an initial basis for recommendations on regulatory reform to strengthen competition and governance within the healthcare and could lead to the initiation of complaints where concerns would be best tackled through a formal investigation under the Competition Act.

While the focus for the review is not yet determined, we believe it would need to take a holistic approach. A deeper understanding of the overall interrelationship of all the parties within this market will enable the Commission to determine any areas of anti-competitive practices and where the incentives to charge higher prices lie. At the same time, the inquiry will be most effective if it focusses on areas where competition policy can be brought to bear on the problems contributing to increasing costs. This paper has attempted to draw a clear distinction between those problems in the healthcare market which relate particularly to potential anti-competitive conduct and those which are essentially governance or regulatory problems. A possible healthcare inquiry should focus on the former. Some of the key issues which may be usefully investigated through an inquiry are summarised below.

The major concern in the healthcare market is over rising prices. We believe the inquiry should analyse the current pricing regime by considering the implications of past government and Commission decisions. As discussed above, there are proponents of a view that the abolishment of collective bargaining and the dismissal of the NHRPL in the industry has resulted in the current impasse over prices in the market. An inquiry should consider if the reference price list is justified and whether it potentially encourages anti-competitive behaviour. It could also look at the current fee-for-service model to determine if it is working or whether it encourages practitioners to 'over service' to increase profit.

An analysis of prices from a competition perspective would need to consider which of the parties has the strongest bargaining power and how this influences the pricing regime. This would mean looking at the bargaining power of medical schemes relative to their

administrators and to their service providers. This would help to determine why medical schemes appear to be ineffective at containing costs.

If we wish to understand the drivers of competition at the level of medical insurance, we would have to look at how consumers choose medical schemes, and what conditions are required to achieve a more competitive market driven by the purchaser.⁷³ A purchaser-driven market could put pressure on medical schemes to compete more actively on price.

Competition strengthens when there is an increase in the number of competing firms. An analysis of the overall healthcare market could determine how to make entry into the market easier. While the Commission could be involved in some parts of this, the Department of Health would also have a key role to play. This process could include looking at the hospital licencing, options for public private partnership agreements to build new hospitals etc. It could also include considering how to increase the number of specialists and how to encourage trained practitioners to remain working in South Africa.

It is clear that the competition authorities also have a role to play with respect to the hospital industry. Retrospective studies on the impact on prices and quality of past mergers would provide a good insight into the effects of hospital mergers. These studies will allow the competition authorities to understand whether the approach taken to merger analysis and control up to now has been appropriate and effective, and will inform future interventions.

In addition, it is widely accepted that imperfect information is a major challenge in the healthcare market. The inquiry could also look for ways of increasing transparency in South Africa. If competition in the healthcare market is to be successful, then there needs to be sufficient information available to stimulate competition by facilitating patients' choice, be it on quality or price.

The areas identified above are by no means the only factors to be considered. The interventions the Commission can make are in relation to the conduct of market participants, concentration of the markets, the interaction between the different levels of the industry and ensuring the protection of the consumer who is less informed in this market than traditional markets. Beyond the scope of the Commission's interventions there is a regulatory framework that can be used to address other concerns.

The healthcare market is complex and a full healthcare inquiry will be challenging and time consuming. The terms of reference for the inquiry will need to be carefully thought out to ensure it will have a meaningful impact in the healthcare market. The inquiry also

⁷³ Van Den Heever (2012)

cannot be seen as a solution to all of the problems of the healthcare market, but rather a start in a process that will require significant cooperation from a wide range of stakeholders.

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