

BHF Response to Submissions to the Competition Commission's Market Inquiry into the Private Health Sector

Introduction

BHF wishes to thank the Competition Commission for this opportunity to respond to the submissions made by various stakeholders to its Market Inquiry into the Private Health Sector.

BHF has some concerns about the lack of response to the Inquiry by a number of role players some of them medical schemes but also others such as the provincial departments of health, especially the Western Cape where the involvement of the public health sector with medical schemes is comparatively higher than it is in other provinces. Provincial departments of health have control over private hospital licences. BHF wishes to note that some medical schemes may not have made submissions to the Inquiry for fear of victimisation by large providers. However this should surely not be the case for the Government Employees Medical Scheme (GEMS) which is one of the largest schemes in the country.

There is also a low response rate from pharmaceutical manufacturers or their representative associations e.g. IPASA and NAPM. Health technology and managed care companies such as MediKredit, Mediscor, MHS and MSO have not made submissions, neither, apparently, has the Council for Medical Schemes, the Health Professions Council, the South African Pharmacy Council or the South African Nursing Council to name but a few. These entities all have more than an incidental involvement in the private health sector even if they are regulatory bodies in some cases. This raises some worrying questions concerning the validity of the findings of the Inquiry and BHF would like to know how the Competition Commission is going to address significant lacunae in industry submissions? How will the Competition Commission be sure of having access to all of the relevant information it needs to be able to draw meaningful conclusions when major players in the industry have not made submissions?

BHF wishes to emphasise with regard to everything contained in this submission that it must be read against the fundamental truth that health care products and services are different to ordinary commodities, and that these differences result in systemic market failure and misallocation of resources without regulatory intervention. No amount of competition will solve the private health sector's problems and the objective of this enquiry should not be the promotion of competition as an end in itself. BHF maintains that to enforce traditional economic

principles of competition in the health care environment for the sake of competition alone is unconstitutional and could be challenged as such in a court of law.

1. *Private Hospitals*

1.1 To the extent that the private hospital groups argue that restrictions on competition should be removed, BHF wishes to counter that it does not believe that the removal of restrictions on competition will improve access to health care services by beneficiaries of medical schemes or the general paying public. Competition does not guarantee needed access to health care services and since such access is constitutionally mandated, it is the obligation of the State to amend the legislative framework governing private health care so as to improve access, not so as to improve competition per se. Mediclinic clearly states in its submission that due to cost and quality benchmark information not being readily available, hospitals cannot easily compete on cost and quality¹. Yet cost and quality are the most important bases on which competition should take place. The whole argument that improving competition will reduce the costs of health care is based on the premise that competition can take place on cost and quality. If there is no competition on cost and quality then no competition is possible at all.

1.2 BHF argues that the private hospital groups as they exist today are a complex monopoly. Natural unbundling of these groups is unlikely and forced unbundling is even less likely. More than 75% of the hospital services market is controlled by less than 5 players. According to Prof Alex van den Heever's report of September 2013, more than R36.7 billion was paid to private hospitals in 2012, representing an increase of 8,75%. If one looks at the distribution of private hospitals across the nine provinces in South Africa, private hospital licences follow the money, not the need for access.

1.3 BHF is in agreement with Netcare's statement² that it is unlikely that reducing the costs of private healthcare will have material benefits for large sectors of the population who are either unemployed or do not have access to regular income. The private health care sector is not by any means the sole, or even a significant, solution to the health care needs of the majority of South Africans. However the State does support the concept of medical schemes and the private funding of health care in the form of the Government Employees Medical Scheme as well as the medical schemes legislation.

- 1.4 It is vital that the costs of private health care are reduced for several reasons. The first and most important reason is the sustainability of medical schemes into the future. If medical schemes can no longer afford to pay for these health services, the entire system could collapse since the private hospitals are heavily dependent on medical schemes for their income. The biggest losers in such a scenario will be the beneficiaries of schemes. However, the public health sector will also be submitted to increased pressure in such a scenario – perhaps it could even be the straw that breaks the camel’s back – and it would be highly undesirable to flood public hospitals with another few million lives. Public hospitals are struggling to meet existing health care needs.
- 1.5 The second reason is the improvement of access to medical scheme membership, and access to health care services, by low income groups so as to reduce cost burdens on the already overburdened public health sector. BHF submits that it is right and proper that those who can afford to pay for their own health care through membership of a medical scheme, or out of their own pockets should they so choose, should be able to do so. The advantage of the medical scheme model is that it allows for cross subsidisation of the elderly and the ailing by the young and healthy if the model is properly legislated and implemented. The medical schemes model also facilitates access in the form of payment, possible through financial pooling, for health care services to which beneficiaries would otherwise not have had access if they had to pay out of pocket.
- 1.6 BHF does not entirely agree with Netcare’s or Mediclinic’s assertions that one of the problems with private health care is that South Africa suffers from a chronic shortage of doctors. The problem is more complex than just the number of doctors in the country. Doctors in South Africa are not fulfilling appropriate roles within the private health system due to factors such as the lack of a sufficient gatekeeping and referral system between general practitioners and medical specialists and the inability of medical schemes to employ doctors as a result of defects in the ethical rules of the Health Professions Council of South Africa (HPCSA).
- 1.7 There is inadequate screening and management of chronic medical conditions such as hypertension, hyperlipidaemia etc. at primary care level within the private health sector. There is also an over-emphasis in the private health sector on curative, secondary, tertiary and quaternary levels of care combined with a significant lack of preventive and primary health care that could obviate the need for higher levels of care to a large extent.

- 1.8 BHF does not support the idea that doctors should be employed by private hospitals because this will not guarantee a reduction in the prices charged by private hospitals for their services. The doctors who practise from private hospitals are invariably medical specialists and not general practitioners. The strategic model of a vertically integrated business is based on the ultimate referral to Netcare hospital and facilities. BHF's submission shows Netcare prices for some services and the impact these prices can have if referral competition is limited in any way. The impact was evident in 2002 when Netcare bought Medicross. Many schemes with a Medicross based plan saw sudden increase in Netcare's market share with exponential, unbudgeted increases in costs to medical schemes.
- 1.9 When Mediclinic, Netcare and the other hospital groups state that they compete for doctors, they are not referring to general medical practitioners. They are referring to specialists. That certain disciplines of medical specialists are in short supply may be true but BHF wishes to emphasise that the services of medical specialists are not optimally used in the private health sector and that if general practitioners shared more of the load, the need for medical specialists would diminish considerably, as would the need for secondary, tertiary and quaternary levels of care in private hospitals.
- 1.10 BHF agrees with Netcare's argument that there is insufficient co-ordination between health care providers involved in treating a single patient and that there is fragmentation in the provision of health care in the private sector. The Health Maintenance Organisation (HMO) model of health service delivery and funding has proven to be efficient and effective in the United States but it is impossible to attempt in South Africa due to misguided ethical rules by the HPCSA concerning the employment of doctors.
- 1.11 Medical schemes are permitted by the Medical Schemes Act to render relevant health services to beneficiaries themselves but the rules governing medical practitioners do not permit schemes to meaningfully explore this option. BHF is in agreement with Netcare's submission³ that the social solidarity principles of community rating and open enrolment are only part of a larger solution that was never fully implemented by government.
- 1.12 Netcare correctly points out that it was originally envisaged that open enrolment and community rating would be accompanied by further regulatory reform, including the introduction of:
- (i) a risk equalisation mechanism,

- (ii) mandatory membership obligations, and (iii) progressive solvency measures.

1.13 These were never introduced whether as the result of a break in political continuity, whether due to changes within the ruling party, changes in party politics, or a loss of institutional memory on the part of the National Department of Health is not clear.

1.14 The structure of the Prescribed Minimum Benefits of the MSA perversely incentivises hospitalisation of medical scheme beneficiaries and unfairly prejudices those whose needs for health care can be met outside of the hospital system. The coverage by medical schemes of so-called “routine care” can be very poor and routine care is often an out of pocket expenditure by the scheme member, whether in the form of a medical savings account or a cash payment to the provider. The PMB regulations and the significant costs associated with them are the reason why routine care takes a back seat in medical scheme benefit design⁴.

1.15 BHF disagrees with Netcare’s statement⁵ that medical schemes (both small and large) have significant countervailing power against Netcare as a hospital group. Mediclinic in its submission also makes the statement that:

“Concentration has not resulted in individual hospital groups such as Mediclinic acquiring market power. As explained below, this is mainly due to the countervailing power of medical schemes and administrators, which prevents the private hospitals from unilaterally imposing tariffs.”

1.16 Life Healthcare argues that:

“Undoubtedly, the degree of countervailing power on the part of the medical schemes and administrators in their interactions with providers has increased in recent years on the back of consolidation in these markets. The funders’ market power has been further strengthened by the growing prominence of Designated Service Provider networks, which give large administrators in particular the ability to channel significant volumes of patients to specific providers.’

BHF does not agree with these arguments of countervailing power. If there is countervailing power it is restricted to only the very largest of schemes such as Discovery Health and GEMS and what happens is that the smaller schemes are expected to fall in with whatever has been negotiated between the hospital groups and these large schemes or lumped with higher increases to make up for any “losses” with the larger funds.

1.17 None of the hospital groups elaborate on the price determination methodology nor the conduct of the group during negotiations with medical schemes. The reference to two funder groups as representing 50% of medical scheme members, is generalized to the remainder of medical schemes who are price takers. The hospital submissions refer to the dominant role of funders and funders as having market power but if this is true then why do some hospital groups behave in a coercive manner during price negotiations? In 2007 when the industry was moving to the net acquisition price model, one of the hospital groups negotiated a 7% fee increase with a funder while the rest of the industry was burdened with a 13% increase. This is not consistent with the alleged countervailing power of medical schemes.

1.18 Mediclinic also asserts that both the open scheme and administrator markets have become highly concentrated. This is disingenuous since the open schemes are not the only schemes in the medical schemes environment and in fact the medical schemes environment as a whole is fragmented as indicated in the submission of the Department of Health. It is too convenient to consider the very small number of very large open schemes, ignore the comparatively larger number of restricted membership schemes and point to concentrations of the former whilst ignoring the latter. BHF submits that medical schemes and administrators do not have as much power to “channel” significant volumes of patients to specific private hospitals as do the medical specialists working at those hospitals.

1.19 Medical scheme administrators in particular, have no power to determine the scheme rules and no power in their own right to contract on behalf of medical schemes with provider groupings. Medical schemes are the ones who contract with designated service providers. The allegation by Life Healthcare that administrators in particular have the ability to channel significant volumes of patients to specific providers is simply wrong. Patients consult medical specialists to whom they may or may not be referred by a general practitioner. Very often the medical specialist is chosen by a patient because the hospital at which he operates is close to the patient’s home or a friend or family member recommends him. The medical specialist only has admission privileges at the hospitals in which he operates and so he is likely to have the patient admitted to

one of these hospitals. This likelihood is increased if the medical specialist has shares in a particular hospital or hospital group.

1.20 BHF has had a number of smaller schemes complain to it over the years concerning the high handed behaviour of hospital groups in conducting so-called 'negotiations' with these schemes. Netcare only admits the power of the large medical schemes to negotiate by stating that nearly half of its revenue comes from Discovery Health and

GEMS⁶. Netcare's claim that smaller schemes have also been able to negotiate aggressive terms with Netcare are unsubstantiated and these schemes are not identified.

1.21 Mediclinic also suggests in its submission that there is some kind of link between the relative sizes of the administrators and that of medical schemes and that to deal with medical schemes is to deal only with their administrators. Suggestions of this nature conveniently ignore the fact that medical schemes have juristic personality and are governed by separate and distinct Boards of Trustees who are tasked with making decisions in good faith with regard to the business of each individual medical scheme. Mediclinic at least admits that it negotiates tariffs with *each* medical scheme or its administrator every year on a national basis on behalf of all of the Mediclinic hospitals⁷.

1.22 BHF wishes to point out that the impression given in the NHN submission particularly in paragraphs 19 -21 that all medical schemes are consolidated under 5 medical scheme administrators that negotiate collectively for the schemes they administer is inaccurate and misleading. The smaller medical schemes often complain to BHF that they have no bargaining power vis-à-vis the hospital groups⁸. The latter tend to negotiate with large, atypical medical schemes such as Discovery Health and then attempt to impose the terms and conditions agreed upon with the large schemes on the small to medium ones.

1.23 The four hospital groupings are dominant in the supply side of the market and do not hesitate to exploit their dominant position. By way of example, on one occasion a hospital group threatened a small scheme that is a member of BHF with a double digit increase in hospital fees if the scheme did not make the hospital group a Designated Service Provider (DSP). Unlike NHN, Mediclinic states that it has contracts with 87 medical schemes, most of which are

administered by one of the 17 administrators in the market. The fact that one hospital group has contracts with 87 medical schemes indicates the imbalance of power in favour of the private hospitals when it comes to negotiating tariffs and the degree of fragmentation of the medical schemes side of the market.

- 1.24 A number of schemes have pointed out that previously when medical schemes engaged in collective bargaining with, for example, private hospital groups and other suppliers, some of the bargaining power enjoyed by healthcare suppliers could be offset but in light of the Commission's position on collective bargaining in the healthcare industry, medical schemes cannot counter the bargaining power of the suppliers in question. Negotiating power has shifted to providers of services as a result of the abolition of collective bargaining processes by the Competition Commission. This has been to the detriment of medical scheme beneficiaries and consumers generally⁹.
- 1.25 The Competition Commission in the past has shown marked inconsistencies in its approach to medical schemes and the purchasing side of the market, choosing at times to see individual medical practitioners, as being representative of the supply side of private health care, ranged against the overwhelming might of individual medical schemes with hundreds of members. It has chosen to conveniently ignore the ever growing presence of the large provider groupings that it has permitted to form. The Competition Commission has over the past few decades permitted the consolidation of private hospital groupings into supply side goliaths in relation to whom the majority of medical schemes have little or no bargaining power. The same could be said for the pathology laboratories.
- 1.26 The supply side of the private health sector is not homogenous. It is wrong to generalise across the supply side and treat it as an undivided whole. This is not purely a game of numbers. The fact that medical schemes represent the interests of the many thousands, if not millions, of individuals who are their beneficiaries does not necessarily pit individual schemes in a more powerful bargaining position vis-à-vis providers. This is due to a number of factors, not least of which is the nature of health care itself¹⁰.
- 1.27 Access to healthcare services is for many people a matter of life and death – if not their own then that of their children. The supplier automatically wields enormous power in such circumstances. To add to this the Prescribed Minimum

Benefits (PMBs) package is completely hospicentric. Medical schemes are legally obliged to provide and pay for PMBs – according to the Council for Medical Schemes (CMS), no matter what the provider charges. Current exploitation of this fact is very evident in the charging behaviour of medical specialists - especially in relation to prescribed minimum benefits.

1.28 BHF has legal opinion to the effect that the CMS interpretation of regulation 8 under the Medical Schemes Act (MSA) is unconstitutional in saying that medical schemes must pay in full for PMBs no matter what the provider charges. Unfortunately the CMS persists with its illegal interpretation and illegally enforces it on medical schemes.

1.29 Medical scheme administrators do not stand in an agency relationship to the schemes they administer and so while they can and do provide expert advice and assistance to schemes in any number of areas, the final decision whether or not to accept a fee structure proposed by a private hospital group, or any other supplier, remains that of the scheme. The relationship between a scheme and its administrator is an armslength contractual arrangement¹¹ which has to comply with the provisions of Regulation 18 of the General Regulations to the MSA. It is not an agency agreement whereby the administrator is given the power to take decisions on behalf of the scheme. See for instance the submission of Metropolitan Health which states that there is a definite arms-length between Metropolitan clients and Metropolitan, with well-functioning independent boards of trustees and scheme management structures.

1.30 Whilst BHF accepts that Mediclinic, Netcare and Life Healthcare are the most powerful of the hospital groups and account for the majority of hospital claims submitted to medical schemes, NHN is also a hospital grouping that could be dictatorial to smaller medical schemes by virtue of the nature of the services it provides and its exemption obtained the Competition Commission which allows it to act as a collective when it comes to bargaining.

1.31 BHF also submits that it is a mistake to consider the four hospital groupings purely from a national perspective because there is often regional dominance¹² by one major hospital group leaving little room for meaningful negotiation on the part of any number of small to medium schemes.

1.32 Open schemes are nationally based but restricted membership schemes are sometimes regionally based. This further weakens the latter's bargaining power when regard is had to the regional dominance of the big three hospital groups. The suggestion of NHN in paragraph 21 of its submission that medical scheme administrators are acting in contravention of the Competition Act in acting on behalf of the schemes they administer is a specious sophism.

1.33 The statement in paragraph 22 of NHN's submission that "medical schemes are, in accordance with the provisions of the Medical Schemes Act, required to provide membership to members nationally" is an utterly incorrect portrayal of the provisions of the Medical Schemes Act. Nowhere in the Medical Schemes Act does it require schemes to provide membership to members nationally.

1.34 Open schemes tend to be national but restricted membership schemes, of which there are many, are often regional. The complaint that medical schemes tend not to negotiate with individual health establishments on an *ad hoc* basis in paragraph 22 of NHN's submission is not valid because it is premised on the assumption that it is logistically possible for a medical scheme to negotiate with each individual health establishment or health care provider that might possibly provide healthcare to its members¹³.

1.35 Medical schemes, especially small to medium schemes have difficulty in seeking to enter into fair and reasonable DSP arrangements with multiple service providers. This is mainly attributable to the market power of private hospitals and medical specialists

and the required guaranteed funding of PMBs at cost¹⁴. In any event, Mediclinic indicates that it has contracts with 87 medical schemes and that it negotiates tariffs with each scheme, or the scheme and its administrator, every year. It is significant that Mediclinic represents a large grouping of hospitals with whom it is possible to have a single tariff structure. The greater the number of tariffs a medical scheme has to deal with, the greater the costs of its administration.

1.36 It is preferable, and fairer to members of all medical schemes, for there to be a single tariff for the same services charged by all providers in accordance with a single procedure coding system. Why should the same service be more expensive for the members of medical scheme A than for medical scheme B? Why should the price of health services vary purely because people belong to

different medical schemes? The contract is, after all, usually as much, if not rather more, between the provider and the patient as it is between the provider and the medical scheme. There are few providers who are happy to substitute the medical scheme completely for the patient in the supply contract. They always hold in reserve the fact that if the medical scheme does not pay for any reason, the consumer is still liable in terms of the consumer's contract with the supplier.

- 1.37 Healthcare services whether delivered in the private or the public sector are a public good. The Competition Commission should not regard health care services in the same light as any other commodity. Regulators have an obligation to protect consumers of health care from exploitation given the constitutional right of access to health care services. Why should the large or powerful providers, such as private hospitals and medical specialists, hold the power to decide whether the smaller medical schemes must effectively subsidise the larger medical schemes because the latter can negotiate better deals or even that members of larger schemes must subsidise those of smaller ones?

This is in effect what happens in the current environment.

- 1.38 Medical schemes do not provide health care services themselves. They pay for the services provided by someone else. Medical schemes are strictly not for profit entities. They fulfil a socio-economic objective – the funding of health care for private individuals. This objective is not confined to the funding of private healthcare. It includes the funding of public health care for private individuals who are not indigent. The public health system requires people who have an income to pay for public health services. They cannot obtain them for free.
- 1.39 BHF supports the assertion of the Department of Health that healthcare is neither homogenous nor substitutable. Different patients have different requirements and the production of health care depends on the patient's diagnosis and even varies across individuals with the same diagnosis. The commodity of health care is, therefore, highly customised and represents a "complicated sequence of adaptive responses in the face of uncertainty".
- 1.40 BHF does not agree with Mediclinic that deterioration in public health services has increased demand for private health services. The decline in medical scheme expenditure on public hospitals could mean that public hospitals are not

billing properly, it could mean that public hospitals do not wish to contract with medical schemes, it could mean that public hospitals are full to overflowing and cannot accommodate medical scheme patients. There is a variety of possible reasons for the decline in medical scheme expenditure in the public sector.

- 1.41 The fact remains that many people cannot afford to belong to medical schemes because the prescribed minimum benefits package is too expensive. These people do not have a choice between public and private hospitals. They are confined to the public health sector. A decline in use of public health establishments by private patients does not necessarily mean that this is due to a deterioration in public health services.
- 1.42 Consumers of health care services are not in a position to make meaningful assessments of the quality of the health care services they receive. Even for experts it is difficult to define the true nature of a particular health care intervention, and measuring the quality of highly technical, health services can be difficult. This makes it difficult to compare the quality of services. However private hospitals do measure quality but they do not publish the results. There is a need for transparent and standardized reporting of health outcomes. Consumers are not in a position to “vote with their feet” as far as health care is concerned.
- 1.43 They are also often not in a position to “vote with their feet” as far as medical scheme membership is concerned since many employers require their employees to become members of a particular member of a medical scheme as part of their conditions of employment. For example see the submission of Metropolitan Health in which it is stated that Metropolitan administers only restricted schemes for employers who typically consider medical scheme membership as an employee benefit, and mandatory membership is often a condition of employment. Employees are therefore locked into a scheme, or a choice of schemes, because of an employer decision. Because of this arrangement restricted schemes differ from open schemes in that restricted schemes do not compete with each other for members.
- 1.44 The imposition of general waiting periods of up to 3 months, condition specific waiting periods of up to a year and pro-rating of benefits where a member joins in the middle of a financial year are practices by medical schemes that can also

hinder to some extent the freedom of movement of members between schemes. These measures are legally permitted and are designed to protect medical schemes for, adverse selection but they can have an impact of members' "voting with their feet". This is just one more example of the fact that the normal free market principles do not apply in the private healthcare environment.

- 1.45 Even where employers don't do so, employees have a choice of only a few open schemes and even then they are often at the mercy of brokers who can have their own agendas in referring people to certain open medical schemes as opposed to others. Issues of consumer choice in the private health care environment are neither simple nor straightforward as they are in other market environments.
- 1.46 Mediclinic and Life Healthcare¹⁵ asserts that utilisation is the reason for increased medical scheme expenditure on private hospitals, It states in its submission that increased medical scheme expenditure has largely been driven by increases in the volume and intensity of services provided and that these increases in utilisation are in turn attributable to factors which include changing patient profiles (in terms of age and disease) and technology. Life Healthcare (LHC) asserts that considering LHC's own patient population, LHC has observed a significant increase in the incidence of chronic diseases of lifestyle over the last decade, with the incidence of hypertension alone increasing from 8% of LHC's admissions in 2003 to 21% in 2013.
- 1.47 The increased disease burden results in increased demand for healthcare services, which, in the hospital context translates into not only more admissions but also increased lengths of stay. LHC says that this is clearly demonstrated in the Econex study which showed a cumulative increase of almost 48% in admissions for chronic diseases of lifestyle amongst the three listed hospital groups between 2005 and 2010, and a 15% increase in length of stay for these admissions over the same time period.
- 1.48 BHF submits that the presentation of increased utilisation as the reason for the increased expenditure on private hospitals "hides a multitude of sins". What in turn causes increased utilisation? If this is interrogated further one finds questions arising such as why should people with hypertension be hospitalised when their condition can

be adequately medically managed in a non-hospital setting? The increase in utilisation could well be driven by poor medical screening and treatment at primary health care level. The reasons for this may be that medical schemes are obliged to pay for hospicentric prescribed minimum benefits and so neglect to provide benefits for adequate medical screening and non-hospital treatment. Another reason could be that people are not obliged to first consult a general medical practitioner before they can see a specialist and so they go directly to a specialist who has all kinds of incentives to admit them to hospital.

1.49 BHF argues that there is excessive use of the word “utilisation” to explain the increased expenditure and that this needs to be unpacked. Is it really attributable to more disease or is it also attributable to billing problems, the manipulation of tariff codes by providers, adverse outcomes as a result of poor quality health services or medical scheme benefit limitations? BHF maintains that a great deal of the increases in cost are due to inefficiencies within the health system rather than increased utilisation per se. For instance the current prescribed minimum benefits package is unfairly discriminatory, poorly defined and structured, hospicentric and encourages hospital admissions for conditions that could be treated outside of hospital or prevented from reaching hospitalisation stage if more effective primary health care services were in place. It is critical to revise the prescribed minimum benefits package in order to remove hospitals and medical specialists from the focus of health service delivery in the private sector.

1.50 BHF has presented convincing evidence on past occasions that private hospitals engage in rebate practices with suppliers of medical devices that push up the price of private health care. There is always gaming of the system going on amongst providers at some level or the other. In the UK, the Competition Markets Authority's (CMA's) final report on its investigation into privately funded healthcare services in the UK estimated that the market power of the UK's three biggest private hospital groups - Netcare's jointventure BMI Healthcare, HCA and Spire - resulted in a consumer detriment of £115m£174m a year between 2009 and 2011, equivalent to about 10 percent of the private revenue of these firms.

1.51 The NHN submission, perversely, confounds medical schemes with their administrators in its analysis that the “market share” of administrators indicates

“a consolidation and concentration of the medical scheme market”. The fact that there are fewer administrators than medical schemes does not justify the identification of medical schemes with administrators. The Medical Schemes Act and its regulations go to great lengths to ensure that there is no control by administrators over the medical schemes they administer by prohibiting the presence of an employee, director, officer consultant, or contractor of the administrator of the scheme, or of the holding company, subsidiary, joint venture or associate of that administrator on the board of trustees of the scheme¹⁶.

1.52 It is therefore misleading to suggest that the number of administrators and their relative market share implies consolidation and concentration of medical schemes. In fact,¹⁷ the HHI concentration of private hospitals is far higher than that of medical schemes and that while medical schemes are slowly consolidating, they are still considered an ‘unconcentrated’ market. Mediclinic points out that the HHI of the private hospital sector is stable from 2004 to 2012. These are convenient figures to quote when much of the consolidation or concentration of the private hospital industry took place between 1999 and 2003 following structural changes made to fees.¹⁸

1.53 BHF concurs with the submission of the National Department of Health where it is stated that the hospital and specialist markets are concentrated resulting in prohibitively high prices and an unequal playing field for fragmented purchasers¹⁹. BHF wishes to reiterate the concern expressed by the Department of Health that the Inquiry Statement of Issues identifies Access, Affordability/Costs, Quality and Innovation as outcomes of interest but excludes any explicit reference to Appropriateness and Equity. The Statement of Issues ignores the fact that the primary outcome of interest is the health of all South Africans and improved access to health care services. What happens in the private health sector is of interest to all South Africans as it impacts on the public health sector too.

1.54 Mediclinic asserts that the primary rationale for doctor shareholding is to establish coownership of the hospital in order to achieve greater integration between the doctor and the hospital and to closer align the interests of the hospital and doctor in respect of cost efficiencies, issues of clinical care and quality and similar initiatives. BHF submits that unfortunately this ‘primary

rationale' in theory may not be the primary rationale that emerges in fact. Doctors who have significant shareholding in private hospitals have a vested interest in hospitalising more patients and in referring more patients to hospital groups in which they have shares even if it is not a condition of shareholding that they do so.

1.55 BHF does not support Discovery's arguments against any form of collective negotiation of hospital and facility tariffs on the basis that this would increase the risk of collusive practices between hospital groups and reduce competition. The system as it is currently actively encourages collusive practices between hospital groups due to the manner in which they are distributed across the country and the fact that they seek to counter the bargaining power of the few large schemes such as GEMS and Discovery that account for the lion's share of their patients.

1.56 There is already greatly reduced competition between hospital groups in the current system as evidenced by the submissions of the hospital groups themselves. Discovery's 'arguments' against a central bargaining approach stem from its belief that it is able to secure more favourable rates from hospital groups than its competitors. This is surprising when considered in light of the fact that in the past Discovery has informed BHF that it had found out that on one occasion at least a smaller scheme had managed to secure a better deal from certain private hospital groups than had Discovery Health Medical Scheme itself.

1.57 BHF in opposition to these views of Discovery on this issue rather supports the submission of Metropolitan Health which observes that an important recommendation in a recent OECD Health Working Paper²⁰ suggests separate negotiation cycles for the technical and price negotiations:

"A suggestion from this review of OECD countries is that South Africa should separate the 'technical' task of establishing a schedule of medical services ranked according to their complexity from 'political' negotiations over overall payments to medical professionals. A technically sound price schedule is a common feature of OECD country health systems. It brings clarity for doctors, those that pay them, and ultimately, the patients that these institutions serve. Today, the South African health care system lacks this clarity. This makes it hard for the public sector to draw on private health care services to expand access to care, and makes negotiations between private insurers and private facilities a more difficult process."

2. *Medical Specialists*

2.1 BHF agrees with the Department of Health that perverse provider incentives associated with reimbursement structures, coding and billing arrangements feed the providers' drive for gain and irrational demand. Medscheme in its submission points out the difficulties currently experienced by medical schemes with the coding issue. It states that for funders, RPL codes still form the basis for payment. Whereas these were negotiated in the past with doctors and maintained by the Board of Healthcare Funders (BHF), the last effective update occurred in 2006.

2.2 Given fear of retribution by the Competition Authorities for perceived price collusion, all collaborative efforts in this regard have ceased. Instead, individual funds decide which codes to add and what rules to apply. Given increasing concerns about the financial impact of code additions and changes within existing scheme reimbursement structures, however, many amendments included in provider guides have not been implemented by schemes. Since 2011, most medical scheme administrators have not accepted any coding changes from SAMA²¹.

2.3 BHF believes that medical specialists in South Africa are overutilized due in no small part to the fact that members of the public and beneficiaries of medical schemes are free to consult directly with a medical specialist. General practitioners are routinely bypassed with the result that there is ineffective or incomplete use of their services and there is inappropriate and ineffective use of the services of medical specialists.

2.4 As pointed out by IPAF in its submission, the reality is that GPs' are routinely bypassed by nurses, pharmacists, clinics, paramedics, emergency unit doctors, occupational health therapists, medical schemes, managed care organisations, healthcare workers, allied health professionals and possibly most significantly of all, by the specialists who can be directly consulted without referral by a GP, thereby resulting in unnecessary costs, duplication of costs and increased downstream hospital costs. This is inefficient and results in the higher utilisation of specialists on medical conditions that could be appropriately treated by a general practitioner. This can also lead to an inadvertent loss of skills on the part of GPs as they are no longer consulted on more complex but appropriate treatment pathways. Other jurisdictions enforce the role of the GP as gatekeeper and have more effective and efficient health care systems.²²

2.5 BHF concurs with the statement by Metropolitan Health in its submission that hospitals frequently claim that they do not control specialists, and that the capital intensive equipment used by radiologists and pathologists are not under their control. The reality is that, even though specialists are not directly controlled by hospitals through employment and explicit contractual arrangements, specialists are very dependent on hospitals for admission rights in the hospitals. Without the expensive equipment and operating theatres supplied by private hospitals, medical specialists would have no place to ply their trade. Without the excess capacity provided by private hospitals medical specialists would have to wait in order to treat their patients which means their income would also be delayed.

2.6 BHF agrees with Metropolitan that the relationship between hospitals and hospital based specialists has resulted in the fact that South Africa has many more capital-intensive and high technology diagnostic scanners than many other developed countries. The fact that hospital bills do not include specialist services like radiology and pathology does not detract from the ability of the relationship between hospitals and specialists to create excess capacity.

2.7 The South African Orthopaedic Surgeons Association (SAOA) readily admits the expenditure by medical schemes on medical specialists must be seen “against the backdrop of the legal framework that mandates certain orthopaedic procedures to be “paid in full and without copayment” whilst other procedures are not covered at all or not in full”. SAOA correctly states that if the legal framework changes medical scheme expenditure would also change. The legislative framework of the prescribed minimum benefits is unfairly discriminatory and skews the system in favour of increased expenditure on prescribed minimum benefit conditions at the expense of others. BHF submits that there is an urgent need to comprehensively revise the policy underlying, and the structure of, the Prescribed Minimum Benefits package.

2.8 There may be some limitation to managed care, however it is required in an environment where practitioners show little accountability. BHF’s submission highlights that this specialty (orthopaedics) is at the top of the list with regards to coding unbundling, a problem that started in the 1990s.

2.9 Informed consent if properly carried out does provide legal protection. The reality is somewhat different and is the root of the information asymmetry. Informed consent is rarely properly obtained by orthopaedic surgeons and other health care providers.

- 2.10 The CMS statistics in the SAOA submission are based on what schemes pay and not based on what providers charge. Out of pocket payments are not included in these statistics. By SAOA's own admission, 3-11% of its constituency charge scheme rates. If CMS figures are based on the amount charged then cost increases would be exponentially higher.
- 2.11 Interestingly SAOA rejects the mandate of professionals' regulator, HPCSA, and believes that the representative body must be the one to determine scope of practice and its accompanying coding. SAOA acknowledges there is a problem with coding and thus billing.
- 2.12 SAOA makes reference to Trustee and Principal Officer remuneration as a problem. This is a result of the CMS investigation and publication of a report on the subject. It is the role of the regulator to ensure reasonable and fair remuneration of trustees and principal officers. There is indeed a need to achieve fair remuneration for all stakeholders involved in the industry. However, the issue is not a general problem across the entire medical schemes industry as represented by SAOA.
- 2.13 SAOA does not see the Fee For Service system as a problem because its constituency comprises the major beneficiaries of this system. With so much noise about orthopaedic coding "abuse", SAOA appears oblivious to the reality.
- 2.14 BHF agrees with Discovery Health (Pty) Ltd that a national standardised pathology request form, which eliminates bundling of tests wherever possible, and includes indicative reference pricing of tests, should be developed and implemented. The current design of pathology request forms has resulted in the increasing cost of pathology over time. Many health systems globally have shifted to more efficient and transparent pathology request forms, which eliminate bundled requests and show pricing of tests. In this regard, HPCSA has not pronounced on the Seedat report published in 2007, and is neglecting its mandate to protect the public.
- 2.15 This radiologists voluntarily charge scheme rates and engage with schemes. This they do to make access to their services affordable. BHF has often challenged the RSSA on the pricing of high tech services. MRIs were introduced in the mid 1990s. The pricing method used was breakeven at 4.5 investigations and a maximum of 7 per unit. These days each unit is booked for over 10 per day. No benefit from economies of scale has

been passed on. The RSSA's comment that this cross subsidises the black and white x-rays has no merit. One could say that charging the scheme rate convenient and affordable for radiologists because the services are already overpriced. The perverse pricing for contrast has now been built into the procedure fee.

2.16 BHF recognizes that RSSA is committed to ethical practice by its members. In the past this group dealt with errant practices. BHF has worked well with the RSSA to standardize all radiological service coding for the industry. Unfortunately, BHF has some reservations about recent unilateral review of the coding by the RSSA.

2.17 The RSSA comments about the limitation of the SAMA Doctor's Billing Manual must be noted. The openness of the DBM lends itself to creative billing practices. The suggestion to use the previously regulated cost methodology is not supported for reasons previously provided.

2.18 Lancet Laboratories states in its submission that the National Pathology Group, membership of which is open to all pathologists who are members of the South African Medical Association (SAMA), publishes coding guidelines aimed at achieving a uniform coding policy applicable to all pathology investigations. The Guidelines do not refer to any value to be ascribed to any procedure performed by a pathologist but only provides guidance on the utilisation of the correct codes. Yet a few paragraphs later Lancet Laboratories states that -

“The Guidelines provide descriptor codes. Each descriptor code is linked to a specific service, which is linked to a unit value, which is in turn linked to a tariff. Tariffs are individually determined by each pathology practice and are typically negotiated with medical schemes and administrators. Generally, the unit values are similar throughout the pathology profession and are a remnant of the SAMA Doctors' Billing Manual ("DBM").”

2.19 BHF wishes to reiterate its concerns around the continued publication by SAMA of the Doctor's Billing Manual as it constitutes an indirect if not direct mechanism for price fixing among doctors. SAMA is subject to a consent order that prohibits it from publishing tariffs directly or indirectly. BHF maintains that the Doctor's Billing Manual is a violation of the consent order. BHF further maintains that the Competition Commission does not have the power to unilaterally vary a consent order since it is an order of the Competition Tribunal and not the Commission.

- 2.20 The continuation of the use of publications such as the DBM and the National Reference Price List by providers and medical schemes indicates that there is a significant need in the private health market for standardisation in certain functional areas and that this standardisation will take place whether or not a central bargaining mechanism exists. This is illustrated by the fact that in Lancet's submission it is stated that in order to avoid the proliferation of medically questionable testing profiles and the use of unacceptable or unreasonable profiles, *only profiles accepted by the NPG may appear on request forms*. This encourages and promotes the standardisation of certain behaviour on the part of doctors despite the fact that referring doctors are allegedly free to request any tests that they consider necessary and appropriate, even if these do not appear on the request form and may do so by requesting those tests in their own handwriting in spaces that are provided for this purpose.
- 2.21 In an earlier paragraph, Lancet states that the NPG Guidelines *discourage the use by referring doctors of handwritten request forms* as this sometimes leads to transcription errors, misreading of test requests, unnecessary tests and higher costs. Discovery Health (Pty) Ltd points out in its submission that the design of pathology forms tends to increase the volume of pathology investigations requested, inflating total costs. Higher levels of utilization are a consequence of the pathology form design i.e. the tick box design.
- 2.22 The problem is that in the absence of a legally recognized central mechanism, standardisation takes place in a haphazard manner in which not all stakeholders have a say and which can result in the system being skewed in favour of particular provider groupings. The Competition Commission in seeking to destroy the central bargaining mechanisms of the private health sector in the early half of the last decade merely succeeded in pushing them underground where they do not operate optimally or necessarily in the best interests of patients. Thus although there is no sanction that can be imposed for non-compliance with the NPG Guidelines the fact is that they significantly influence the behaviour of doctors and pathologists because they have been agreed between them. Discovery Health observes that the limited competition in the radiology and pathology markets is aggravated by the fact that referring doctors are not aware of the prices of investigations, and by the fact that scheme members have limited incentives to be aware of prices, as most costs are covered by schemes. BHF supports this.
- 2.23 The need in the private health care market for standardisation and a central bargaining mechanism is reinforced by the submission of the Radiological Society of South Africa

(RSSA) according to which the RSSA submits that the private health care market is unique and as a result needs a central mechanism to determine guideline prices/tariffs/reimbursement rates. The RSSA observes that historically there has always been some collective action in this regard whether it has been through annual negotiations of representative associations (between 1993 and 2003) or more recently in response to the DG's call for the submission of information, on health care costs, in terms of the RPL Regulations.

2.24 The RSSA says that unfortunately the setting aside of both the RPL Regulations and the 2009 RPL by the High Court has left a vacuum in the pricing of health care services and has contributed to price increases which are above the CPI (although CPI is not an appropriate inflationary measure for health care services). This demonstrates that the RPL had some containing effect on price increases. It is not only medical schemes that need some form of regularized tariff or benefit structure but also many providers. The fact that radiologists routinely charge what medical schemes are prepared to pay is indicative of the fact that they value the certainty of payment that this brings along with the avoidance of burdensome administrative and debt collection processes. Indeed the RSSA goes so far as to say that:

“Because health care services are complex and medical schemes need to process significant claim volumes, a coding system has developed over the years to accurately and uniformly describe the services which healthcare professionals provide. While attaching a price or a fee to a particular service is discretionary, as we will demonstrate hereunder, the more recent absence of such a guideline has arguably harmed consumers. We note in this regard that the guideline tariff was also sensitive to the skill / experience of the professional, the time required to perform the service, as well as the practitioners' costs.”

2.25 BHF is in agreement with the RSSA that radiologists should not be employed by private hospitals as this would only strengthen the already over weighted balance in favour of private hospitals and further consolidate the provision of health care services on the basis of the existing private hospital oligopoly which the Competition Commission has permitted to arise over the last two decades. The Competition Commission is not a neutral external observer of the private health care system in South Africa. It has become part of the problem.

2.26 The Department of Health points out that there is no regulated standard regarding service definitions and coding, resulting in confusion for patients and perverse provider

incentives. BHF in its submission gave examples of how procedural coding is manipulated by specialists in order to increase fees without increasing the nature or level of quality or service to the patient and submits that there is an urgent need for a uniform, standardised procedure coding system that must be regularized across the entire private health sector in order to prevent unnecessary and wasteful expenditure due to the manipulation of the coding system and tariffmanship. This is supported by the statement in the SAOA submission that there is “a tremendous need for clarity on many codes, described as ‘grey areas’ and for guidance as to how to bill and what codes to use to correctly describe the professional acts that constituted the service”.

2.27 BHF submits that medical specialists do not set their fees with reference to the costs they incur, the time they spend and their level of expertise as would experts in other fields. Thus there is no significant competition on the basis of price or quality amongst medical specialists. Most medical specialists set their fees with reference to existing tariffs or past tariffs because of historical factors within the private health care system and the fact that there is still a need on the part of health care providers for some form of centralised bargaining in order to co-ordinate the determination of fees and tariffs with the benefits that medical schemes are prepared to offer their members.

2.28 This is borne out by the fact that SAOA states in its submission that the bulk of their member respondents indicated that they use medical scheme tariffs as a reference point in setting their fees. A significant number of respondents to SAOA’s survey stated that they use medical schemes tariffs, percentages of the old Reference Price List or the old SAMA private rate as a reference point. Only 30% of respondents said that fee setting should be done with reference to special interest and unique services. SAOA states that this does not seem to be the reality.

2.29 The statement of the SAOA that medical schemes control orthopaedic surgery through the pre-authorisation system is incorrect. The lion’s share of orthopaedic surgery falls into the category of prescribed minimum benefits and medical schemes have little choice but to pay for orthopaedic surgery once it has been established that it falls into this category. Medical schemes are not free to decide on an ad hoc basis whether or not to pay for orthopaedic surgery.

2.30 They are bound by their rules which have to be approved by the Registrar of Medical Schemes in order to be valid. When medical schemes do so-called pre-authorisations they are effectively checking the schemes rules and the regulations under the Medical

Schemes Act in order to ascertain whether the proposed surgery is in fact covered in terms of the rules or regulations. If it is not covered then schemes will inform the member and the provider that they are unable to pay for it. Medical schemes are not legally permitted to act beyond the scope of their rules or the Medical Schemes Act and its regulations.

2.31 The co-payments to which SAOA refers are not in fact co-payments as generally understood by medical schemes but payments over and above what the medical scheme is prepared to pay. A co-payment is not over and above what a medical scheme is prepared to pay but rather the member's portion of the full amount that the scheme is prepared to pay. Many specialists charge fees that are beyond what medical schemes can pay in terms of their rules and so the patient has to pay these out of pocket. These are not co-payments.

2.32 BHF agrees that it is reprehensible that the Department of Health has not reviewed the prescribed minimum benefits regulations as it is required to do every two years. It is partly because this has not been done by the Department of Health that there are so many problems with prescribed minimum benefits. The fact that most orthopaedic surgeons use the SAMA Billing guide, as stated in the SAOA submission is problematic. BHF has long maintained that the publication of the SAMA Billing guide (or the Orthopaedic Coding Manual which is a derivative of the SAMA Billing Guide) is a violation of SAMA's consent order with the Competition Tribunal which prohibits it from publishing any form of tariff.

2.33 The capacity of a scheme to "actively direct patients to other practices" as claimed in the SAOA submission is limited. Schemes merely inform members which are the scheme designated service providers for the purposes of prescribed minimum benefits as they are entitled to do. The regulations under the Medical Schemes Act make provision for designated service providers in the sections on prescribed minimum benefits and managed care. Members can choose to use non-designated service providers if they are prepared to pay the co-payments that may legitimately be imposed by the scheme.

2.34 BHF agrees with SAPFF' submission that there is a need for a mechanism for the central determination of a tariff for evidence based diagnosis and treatment codes. The tariff should be based on sound clinical practice and evidence based medicine and should include a procedural coding system that is not a guideline but is mandatory for all medical specialists and other providers.

2.35 BHF is in general agreement with the averments of the SAPFF that the private health sector cannot replace the public sector or service every public health sector patient. It is nevertheless a valuable asset in that it detracts from the burdens of the State in the delivery of health care services and diverts the health care demands of a part of the population to another sector. Currently the only cost to the state of the private sector is the cost of the tax credit allowed as an offset against medical scheme member contributions. SAPFF makes the debatable point that one cannot speak of the inequity of 'financing' of healthcare when comparing what individuals choose to spend on their own healthcare using their own, private, after tax income, with what the State chooses to spend of the national budget on behalf of every citizen to supply them with free health care.

2.36 A fairer comparison would be what the State spends on medical scheme beneficiaries by way of the income tax rebate with what the state spends per capita per annum on the remainder through the public health system. BHF agrees with SAPFF that the role of the GP in directing patients to appropriate practitioners or health services is critical to the functioning of the healthcare system. The GP as a result of his or her training has a better idea than the patient as to whom the patient should see. This avoids unnecessary visits to the wrong caregiver and waste of valuable resources. Apart from these few points BHF disagrees with the submission of the SAPFF insofar as it seeks to paint medical specialists as victims of both the National Department of Health and the medical schemes industry.

2.37 While it may be pro-competition, none of the labs make reference to the inefficiency of having two or more labs in each private hospital in the urban areas nor do they suggest how access to their services can be made more affordable. Pathcare makes reference to duplication of services in respect of the NHLS services. Resource allocation based on needs analysis, not the promotion of competition, is vital in healthcare,

2.38 There is no suggestion by any pathology laboratory group on how point of care testing can be standardized and rolled. This is not surprising as this would erode their revenues.

2.39 The NPG guideline is fraught with problems. No remedy has been applied nor any has any follow up engagement been entertained by NPG. BHF's concerns are how these guidelines will drive over-utilisation and unnecessary cost.

- 2.40 Pathology cost, particularly in-hospital cost, has escalated significantly over the last 2-3 years. This may be related to the higher than usual admissions to ICU/HCA which are thought to be supplier driven rather than demand driven.
- 2.41 HQA data indicates that there is significant underutilization of essential pathology in day to day care of patients. This is synonymous with poor quality of care delivery to patients.
- 2.42 Pathcare refers to funders not willing to discuss code changes when for years the NPG closed the door on BHF and Verirad. Dialogue does not take place if parties are not willing to talk and resolve differences. It is regrettable that the NPG approach has always been “their way” or “no way”. To date NPG has not conceded on problem issues raised.
- 2.43 Interestingly, Lancet Laboratories acknowledges having different prices with different funders – a clear contravention of the ethical rules of the HPCSA (not referring to special pricing for low cost benefit options).
- 2.44 The submission of Lancet Laboratories states that it negotiates tariffs with medical schemes and administrators every year for the succeeding year. “These tariffs are negotiated per test and while they may differ from fund to fund, these differences are not material.” Lancet gives two reasons for this. First, a single scheme administrator will more often than not effectively negotiate on behalf of several funds and so the tariff charged to these funds will usually be the same or extremely similar. Low-cost benefit options are the exception to the rule. Second, medical schemes and administrators typically only agree to a Consumer Price Index adjustment on the previous year's tariff and rarely agree to a complete recalibration on previous years' tariffs. This proves once again that competition does not operate in the private health sector in the simplistic manner envisaged by the Competition Commission when it made its findings in 2003 against the representative associations in the private health sector.
- 2.45 In BHF's experience, the Competition Commission has failed throughout the years to understand or appreciate that the private health sector does not operate in the same way as other markets and principles of economics that may operate in other markets do not operate in the private health sector or operate in very different ways to those envisaged for markets in general. Medical schemes represent volumes – volumes of claims, volumes of patients, volumes of contributions, volumes of data – that all have to be processed by computers in a logical, uniform and predictable way. This predictability is a prerequisite for the successful functioning of medical schemes and for certainty on

the part of their members as to their entitlements concerning benefits, the payment of their claims and ultimately their access to private health care.

2.46 BHF agrees with Lancet Laboratories that vertical integration of pathology laboratories with private hospitals is undesirable. It will simply serve to further consolidate the already overweening power of the private hospitals in the private health care sector.

3. *General Practitioners*

3.1 All medical practitioner submissions make reference to the cost methodology to determine their remuneration levels. This is convenient because of one of the major flaws in the methodology. BHF criticism of the CMS/DOH proposal and studies was included in the first BHF submission (BHF's Powerpoint presentation). One of the major weaknesses is the under-estimated working time which results in over-estimated cost per minute.

3.2 Input cost is included in cost per minute, however, as the procedure relative value unit already includes technical difficulty and cost of equipment, it becomes double jeopardy for the patient. RVU is multiplied by Rand Conversion Factor.

3.3 It is not the responsibility of the patient or public to keep inefficient practices profitable. While cost should be considered in determination of fees, equally it is important to consider affordability and willingness to pay.

3.4 BHF supports the comments by many service providers, particularly those that charge scheme rates, calling for central mechanism to negotiate prices. Interestingly, those whose constituency charges higher than scheme rate, are demanding cost based methodology.

3.5 The problem at GP level is that of revenue rather than fee per line item. A BHF study in 2011 presented to the KZNMCC showed, using three different methodologies, that there is an oversupply of GPs (33+%) in the private sector. This indicated there are insufficient number of patients seen by GPs. More information is available if required by the Inquiry.

3.6 Medical scheme benefit design over the years has resulted in less benefit for primary care, thus the lower payout to GPs in the CMS report. These lower payout levels have little to

do with the remuneration levels of GPs and more to do with shrinking benefits related to hospi-centric benefit design.

3.7 At this level of care, the major cost driver in the system is “quality of care”, more particularly lack thereof and the lack of co-ordination of care, indirectly influenced by HPCSA. See BHF comments in its submission. GPs are “not in a position to elaborate on downstream costs” indicates the lack of accountability and absence of co-ordination of care.

3.8 BHF supports the need for the primary care practitioners’ co-ordination/gatekeeper role and the need for the HPCSA to align itself to government and progressive health policies.

3.9 The IPA Foundation (IPAF) submission contradicts the assertion of other health practitioners regarding medical scheme dominance. IPAF highlights that medical schemes are regulated by CMS and that the IPAF have working relations with funders. Clearly, working relations are only possible if there are non-dominant parties. “If a doctor however deems it clinically or medically necessary authorization is available on a case by case basis from the scheme”. Why does the IPAF have working relations with funders while other health practitioners perceive the funder as dominant? Are they engaging funders with different expectations and attitude?

3.10 Contrary to its statement, through its publications SAMA does make recommendations on billing, sometimes offering incorrect advice. Examples were presented in BHF’s submission. Publication or distribution of SAMA’s Guide to Billing without adequate interrogation of content by the editors is rubber-stamping billing recommendations of the specialty societies.

3.11 Medical schemes have little control over the practitioner billing levels, other than when the latter are contracted into a network. Medical practice, is a business, and has a choice to contract or not to contract, to charge the scheme rate or higher fee levels, to balance bill or not, to demand cash up front or not. Medical scheme contract take up is limited especially for specialists who are more likely to charge higher fees. There are more GPs, in percentage terms, that contract with medical schemes. This is noteworthy because it is specialists that medical schemes have problems with.

3.12 The DBM published by SAMA does not sufficiently provide guidance and interpretation on how codes are to be used. The practice of keeping a guide to billing independent from a coding schedule is the root of the coding (unbundling) problem. Professional

societies e.g. orthopaedic and cardiothoracic, independently produce guides to billing without rigorous checks and balances. The medical coding is far from similar to CPT and is thus open to interpretation and possible billing abuse. By its own admission SAMA did have checks and balances with other users of the coding system. The consequence of which is funders have a different coding schema to that published by SAMA and patients are caught in the middle of the debate.

- 3.13 SAMA omits to add in its submission that it was party to the court challenge that led to the scrapping of the 2007, 2008 and 2009 fee schedules leading to the current vacuum regarding a reference price list.
- 3.14 SAMA confuses market share with pricing. The reduction in GP market share of scheme payout is a function of benefit design rather than price reduction.
- 3.15 There is definitely room to reduce non healthcare costs. This is tightly monitored by the regulator (CMS) and through its interventions has come down in real terms since 2006. Consolidation and health reforms in the industry should reduce these costs further.
- 3.16 SAMA would like its constituency to charge more than the contracted rates. It laments that medical schemes only pay scheme rates to contracted providers! In a business environment, the provider must be free to opt out of the contract if dissatisfied with the fee offered.
- 3.17 Regrettably most DSP contracts are price based and not value based. BHF has made reference to the lower levels of quality of care delivered in the private sector. There is a need for healthcare accountability to be included in the contracting terms.
- 3.18 Medical schemes advise of the care they will fund. It is the medical practitioner that has the responsibility to discuss the treatment options with the patients and choose the appropriate one that best suits the patient's needs. In an environment where there is limited or no accountability, medical schemes are forced to consider efficiency measures. How they do it is regulated by the CMS.
- 3.19 Managed care was introduced to overcome the lack of accountability for care through narrowing the variance of care (improve efficiency using evidence based medicine and health economics) and improving quality of care. To date emphasis has been on the former, in a finance centric environment, and the latter less successfully. Formularies and treatment protocols are used for efficiency and not at the expense of quality. These

activities are inspected and regulated by the CMS. These are consistent with international practices to drive efficiency and increase access.

3.20 SAMA is using statistics in a conflated manner and drawing strange conclusions. The increase in hospital cost and market share of payouts is a result of managed care failure. Decrease in GP market share is because of lower fees. Increase in allied health market share is because managed care companies are directing patients away from doctors.

3.21 SAMA asserts that if a practitioner contracts with a scheme, except in the case of low cost benefit options, at price X, then the practitioner should be able to contract and charge higher prices to patients for the same service, in contravention of the HPCSA ethical rules.

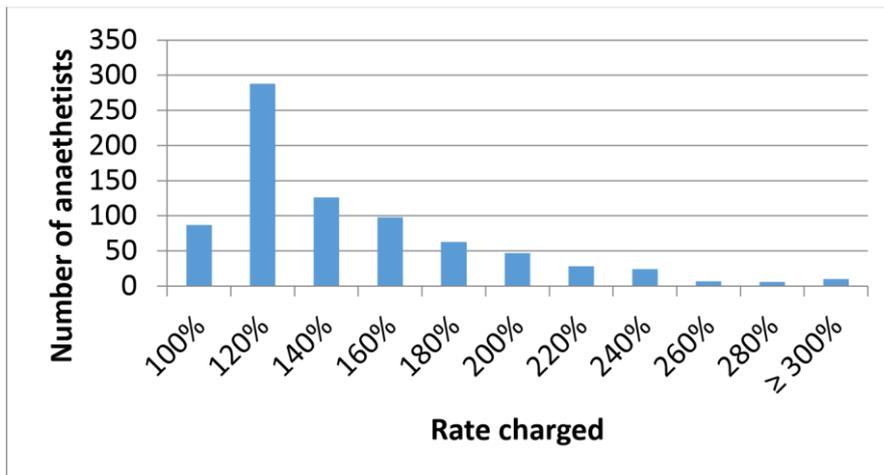
3.22 SAMA wants the few delinquent practitioners to be treated with kid gloves and asserts that medical schemes do not have an obligation to recover overcharges from delinquent practitioners. This indicates the limited understanding of forensic services and regulations governing medical schemes. The medical schemes industry does not resort to bully tactics as generalised claims by SAMA and EMC suggest.

3.23 DSP fees signed with large schemes are not necessarily available to smaller schemes. Providers often charge smaller scheme members more. This can be described as a discriminatory practice.

3.24 SAPPF emphasize “great quality of care”, which is somewhat misleading because funder information indicates limited accountability on the part of doctors in respect of treatment options and estimated cost of care with patients, and quality of care delivered.

3.25 When practitioners enter the private sector it appears they want all business rules to be in their favour. Medical schemes must pay them directly regardless of the level charged. It is claimed that those funders that do not pay the doctors directly are acting in bad faith because medical scheme members spend the money refunded to them by the scheme and do not settle their doctor’s accounts. While the problem is real in some circumstances, this is a very narrow and naïve view of private business practice. It appears that SAPPF would like a scenario where doctors should be allowed to charge whatever they feel appropriate and funders must align their benefits with the doctor’s fees and must not have their own scale of benefits.

3.26 According to the SAPPF all specialists are providing services at a loss if they charge the scheme rate. However, most specialists working in the southern suburbs of JHB charge medical scheme rates and are doing just fine. Perhaps the specialists in the southern suburbs have practices and lifestyles that are different to their colleagues in the north of Johannesburg. Furthermore, the mode of the distribution of specialist billing relative to scheme rate is 120% which is the level at which most specialist DSP contracts are pitched. Many at this level would probably have charged scheme rates if there was no DSP contract fee on offer. See distribution below.



3.27 There are regular references to the “Patel study”: SAPPF has speculated based on comments made by the HPCSA. The Patel study’s results are not too dissimilar to the result which actuary Christoff Raath presented above.

3.28 The narrow interpretation of regulation 8 by the SAPPF does not mean illegitimately applied codes (unbundling) should be fully funded by medical schemes. Furthermore, regulation 8 was introduced when the context was different. When regulation 8 was introduced there was a price negotiation mechanism, 80-90% of specialists charged scheme rate, there was no price vacuum as exists currently and other than in orthopaedics there was no unbundling of codes.

3.29 BHF does not support the SAPPF inflator method. Surgical procedures already have a higher RVU for the technical and higher cost component. To then have a higher inflator for surgical will lead to exponential increases in payouts for surgery. Furthermore, use of the standard deviation as the dispersion factor together with a median is an inappropriate and conflated view of the use of statistics.

- 3.30 It must be noted that the BHF has not endorsed the SA Classification of Health Intervention (SACHI) arrangement for coding. BHF attended two meetings as an observer. At the second meeting BHF interrogated various coding proposals and it was clear that there are very few checks and balances as in the SAMA DBM case. BHF has not been invited to any such meeting since.
- 3.31 BHF has commented on the employment of doctors in its submission. Suffice to say that non-profit organisations do not have shareholders, and carry out activities that are of public interest. Autonomy of doctors is not curtailed when service is rendered as a public good. Furthermore, no single ethical rule is greater than another. A doctor has to think of the patient as well as the population from which the patient comes.
- 3.32 Medical schemes have high reserves because this a regulatory requirement and not because schemes chase profit. The last five annual reports of the CMS indicate that medical schemes are keeping their heads above water with investment returns and not as a result of operating surpluses.
- 3.33 It must be noted that SAPPF like all other health providers supports a comprehensive PMB and the wide interpretation of regulation 8 because this fulfills its constituency's need, but does not support a regulated maximum price at which these services should be procured. SAPPF proposes a fee structure that is 200-300% of the scheme rate while stating that it supports affordable access to care.
- 3.34 Interestingly, suggestions on coding changes make no reference to the need to perform an impact assessment to assess the effects that the change may have nor whether health needs should be considered.
- 3.35 While BHF is cognizant of the very high malpractice cost and the effect this has on professional insurance, perhaps part of the solution might be for health professionals and their representative bodies to focus on quality of care delivered.
- 3.36 In a private business environment, practices have the democratic right to sign or not to sign a DSP contract presented by a scheme. There is no coercion from medical schemes as some submissions would suggest. The perceived pressure to sign a DSP contract is not caused by the medical schemes but by market factors.

4. *Medicines and Medical Devices*

- 4.1 BHF is in agreement with Discovery Health's assertions that the system of medicines registration in South Africa is problematic due to time delays and the fact that pharmaceutical companies that wish to register new medicines do not need to provide clinical novelty or added clinical value. BHF also agrees that South Africa's approach to medicine patents does not require substantive patent examination. As a result, South Africa grants a high number of patents relative to other countries, and has the highest medicine patents approval rate of all BRICs countries. The inappropriately easy access to patent protection and the practice of patent evergreening harms competition and precludes access to affordable medicines. BHF supports Discovery Health's submission that consideration should therefore be given to allowing medical schemes to procure medicines for treatment of PMB conditions at state tender prices. This has been BHF's view for the past 24 to 36 months and communicated to the National Department of Health.
- 4.2 BHF supports Discovery Health (Pty) Ltd's proposals that consideration should be given to setting a minimum price differential between generic prices and prices of originator products and that consideration should be given to allowing medical scheme members access to state tender prices for all medicines of public health importance (including vaccines, and medicines for TB and HIV/AIDS) as well as for all medicines used to treat PMB conditions.
- 4.3 BHF also agrees with Discovery that the National Department of Health, the Medicines Control Council and the Pharmacy Council should jointly publish and endorse a national generic medicine database, including a full list of all recognised generic medicines and their prices and that the regulations calling for removal of all rebates and incentives in the pharmaceutical supply chain, and for transparency in logistics fees should be implemented. Any increase in dispensing fees to compensate pharmacies for lost income, should be accompanied by proportionate reductions in SEPs.
- 4.4 While the BHF sympathises with the plight of community pharmacists, BHF objects to the allegations of the ICPA that medical schemes are misusing designated service provider arrangements. The complaint of the ICPA is in essence that community pharmacists cannot compete against the 'big guns' such as Clicks and Dis-Chem pharmacies but they lay the blame for this at the feet of medical schemes²³. Medical schemes cannot be held accountable for the failure of a business model – namely the community pharmacy. The Regulator cannot be expected to maintain or preserve a particular business model

beyond the bounds of efficiency and its capacity to render services at competitive rates. Regrettably the community pharmacists held out too long with unreasonable demands for a regulated dispensing fee; the industry has moved on.

- 4.5 Community pharmacists seem to think that the world owes them a living. This is not the case. If a business model can no longer deliver an efficient and cost effective service due to changes in its environment then it becomes obsolete. That is the law of the marketplace. Medical schemes are legally permitted to seek the most cost-effective and financially viable solutions for members in accessing their medicines. Why should the law be modified specially to preserve a business model if it can no longer offer value for money? Why should the failure of a business model be attributable to medical scheme's legitimate efforts to achieve efficiency and cost effectiveness. When Pick n Pay, Spar and Shoprite came along, the corner grocer became a thing of the past. No-one said "we must preserve the corner grocer model at all costs".
- 4.6 The ICPA demonstrates its ignorance of the medical scheme regulations and basic economic principles when it states that "no due consideration is given to the out-of-pocket cost to the patient to access the chosen Designated Service Provider by the schemes, especially where the provider is outside the area of the patient's home". Firstly, medical schemes do not exist to cushion their members against every conceivable cost they may sustain in accessing health care services. Everyone has to travel some distance to see a doctor, visit a pharmacy or be admitted to a hospital since these facilities are seldom conveniently located outside a member's backdoor.
- 4.7 Secondly the regulations expressly state that no co-payment or deductible is payable by a member if the service was *involuntarily* obtained from a provider other than a designated service provider.²⁴ The regulation goes on to describe what is meant by "involuntarily obtained" by stating that if there was no designated service provider within *reasonable proximity* to the beneficiary's ordinary place of business or personal residence then it is deemed to have been involuntarily obtained. There is thus provision in the regulations for a situation where, if the DSP is too far away (meaning transport costs are too expensive, time taken to access the DSP is unreasonably long etc.) *then the member can use another provider without being charged a co-payment of a deductible*. One cannot have one's cake and eat it.
- 4.8 The principles of competition are essentially the law of the jungle applied to the market place. One cannot say one wants a lot of small players in a market when the law of the

jungle (and the fundamentals of competition) favour the strongest or the largest. Competition law is a self-defeating concept as the emergence of the oligopoly in the private hospital market demonstrates. Consolidation is natural behaviour for market players and the logical outcome of unchecked competition. This is one of the reasons why BHF maintains that increased or improved competition is NOT the key to the problems in the private health sector, it is at best a meaningless concept and at worst actively detrimental to the consumer of health care goods and services.

4.9 The ICPA demonstrates its ignorance of the co-payment system when it states in its submission that “by allowing schemes to charge penalty co-payments, schemes are allowed to penalise beneficiaries for fictional damage that were not suffered”. Copayments are not made to schemes. They are most often made to the pharmacy that is not in the scheme’s DSP network. The ICPA seems to think that it is to the advantage of a scheme to have a patient make a large co-payment to a provider demonstrates a total lack of understanding of the fact that medical schemes are bound by their rules and that the co-payment that medical schemes usually impose for out of network services is the difference between what the scheme would have paid to the in network provider and what the out of network provider is charging.

4.10 The ICPA provides no hard evidence of so-called “punitive penalty payments” Schemes are not for profit entities. They do not exist to rip their members off by “making money” wherever they can. The object of a co-payment is not to reimburse a medical scheme for any form of loss or damages but to encourage members to use providers who have contracted with the scheme and whose rates have been agreed with the scheme so that the scheme has more certainty as to its liabilities and can budget more effectively. Copayments also reinforce the schemes contractual arrangements with the DSP insofar as the scheme undertakes to refer members to the DSP in exchange for lower prices.

4.11 The ICPA seems determined to blacken medical schemes on the basis of an apparently extremely limited comprehension of the manner in which they operate and the reasons therefor. The ICPA clearly has a grudge against medical schemes because they do not always contract with community pharmacists or the community pharmacists do not want to contract at the scheme’s DSP prices. Medical schemes are unlikely to contract with community pharmacists if this promotes inefficiencies, reduces cost effectiveness or otherwise adversely affects the interests of the scheme and its beneficiaries. Medical

schemes have to be run as a business even if they are not or profit entities otherwise they would soon be out of business altogether.

4.12 The ICPA also makes the statement that the total payment by schemes to service providers remains the same whether they have DSP status or not. It seems to escape the ICPA's notice that medical scheme benefits are dictated by their rules which have to be approved by the registrar for medical schemes and that medical schemes are bound by their rules. The terms of a contract between a medical scheme and a DSP may not necessarily be that the scheme pays the DSP higher prices although in highly unusual cases, such as that of Discovery Health, this can and does happen.

4.13 It may be that a scheme contracts with a DSP on the basis of constant availability of a service to their members at all times or the use of certain treatment protocols or billing procedures such as the electronic submission of claims. There are many reasons why a scheme could select a DSP and if contractual flexibility and discretion were to be abolished by legislation in this regard one might as well do away with DSPs altogether since the scheme could not derive significant advantage from DSPs arrangements. Different schemes have different needs and therefore would have different DSP contracts based on their particular needs.

4.14 From its submission the ICPA also apparently does not understand the concept of the Single Exit Price and the fact that regulations govern what must be charged for a medicine. It is not clear why the ICPA is of the belief that medical scheme co-payments "force" pharmacies to sell their "goods" below the price at which they bought these goods. There is no viable rationale behind the statement to this effect at page 10 of the ICPA's submission. Medical schemes are permitted by the medical schemes regulations to form networks. A network by definition include some providers and excludes others. Otherwise there would not be a network. In law a person, including a medical scheme, is allowed to choose with whom he, she or it contracts.

4.15 There is no obligation to contract with everyone. Basic commercial principles, and competitive forces, usually indicate with whom it is best to contract – those who offer the best deals. The citation of a definition in the medicines pricing regulations as to what the phrase "dispensing fee" means in the regulations is used to argue that medical schemes should not agree with providers on a percentage dispensing fee that is inclusive of VAT. The purpose of a definition in regulations is to explain what is meant by the defined term

when it is used in the regulations. It is irrational and contrary to basic principles of statutory interpretation to interpret a definition as prohibiting the inclusion of VAT in the dispensing fee. The submission of the ICPA is naïve and simplistic and BHF objects to it in its entirety as being based upon abnormal and irrational premises and a total lack not only of understanding of how markets operate but how to interpret and apply basic legal provisions within the private health sector.

4.16 BHF is in agreement with SADA's statement that for any inquiry to be sufficiently constructive in the context of the South African health landscape, a focus on the private health care sector cannot exclude proper consideration of the dynamics of and costs in the public health care sector. BHF has stated as much in its submission. A prime example of this issue is that of the difference in the prices of medicines between the private health sector and the public sector. Whether or not this is the intention of the pharmaceutical manufacturers they are effectively using the private health sector to subsidise the public health sector in the purchasing of medicines due to the levels at which the Single Exit Price for medicines are set. The RSSA makes the same point in stating in its submission that the private and public health care sector in South Africa have a symbiotic and mutually dependent relationship.

4.17 In addition the private sector patients are indirectly subsidising public sector patients through the payment of VAT on private health care services and products including medicines. BHF submits that VAT should not be included in the Single Exit Price or medicines because not all suppliers of medicines are VAT vendors – they do not qualify for registration as a VAT vendor due to the provisions of the VAT Act.

4.18 BHF disagrees with MSD's submission, which refers to the Foreign Corrupt Practices Act, the SA Code of Marketing Practice, MSD's Code of Conduct, HPCSA, SANC and Pharmacy Council rules and then makes that statement that:

“These rules, together with provisions on informed consent, and the provisions of the Consumer Protection Act, should protect patients against being victims of information asymmetry and being subjected to third party influence on the treatment choices they exercise”.

4.19 The mere existence of rules does not guarantee adequate information to the patient sufficient to ensure informed choices and decisions concerning health care. For example, a patient only receives a legally mandated patient information leaflet (PIL) in the box that contains the medicine once it has already been supplied to him or her. The patient does not have access to the PIL before he has the medicine in his hands.

Furthermore many patients are illiterate or functionally illiterate and rely utterly on the advice of the health care professional prescribing the medicine.

4.20 Patients are seldom, if ever, given a choice between medicines in the doctor's consulting rooms with the benefits and drawbacks of each being explained and discussed by the provider and the patient. This just does not happen. BHF submits that there is massive information asymmetry as far as medicines are concerned but also that the private health sector generally is characterised by significant information asymmetry. The Department of Health's submission is in agreement with this view as it states that:

“Normative economic theory assumes that consumers are the best judge of their own welfare, know their preferences, and will specify their demands for commodities accordingly. The demand for health care is a derived demand, where consumers demand health, rather than care itself. This implies that the consumer must be armed with full knowledge regarding the production relationships and functions governing effectiveness of available treatments in order to appropriately define their preferences. It is widely accepted that for the most part, this is not the case. Patients face unavoidable uncertainty regarding their future health needs, as well as the services that they will require in order to meet these health needs.”

4.21 BHF endorses this statement and is of the belief that information asymmetry is an unavoidable characteristic of the health care environment given the gaps in technical and specialist knowledge between providers on the one hand and consumer's on the other combined with the consumer's vulnerability due to the nature of the need for healthcare services and products. A consumer or his child will not necessarily suffer intense physical pain, disablement or lose his life if he has no access to bread, shoes, cosmetics, furniture or a car. The same cannot be said where there is no access, or insufficient access, to health care services.

4.22 A consumer does not know in advance whether a medicine will cure him or kill him. Both are a possibility. He cannot know in advance whether a surgeon will be able to rectify his health condition or maim him for life. Both are a possibility. Even after the event, it is difficult for a patient to know whether or not the surgery was well done or poorly done, whether the medicine did in fact help or whether he would have recovered naturally without the use of the medicine in due course.

4.23 Consumers are not in a position to compare the efficacy of the services or the level of expertise of one GP with another GP. They only know whether or not they like him or

her as a person. A GP could have the best bedside manner in the world and at the same time be the least experienced, least knowledgeable and most dangerous GP in the world. The patient can only evaluate the bedside manner. Consumers of healthcare goods and services have no control over demand. The Department of Health has rightly said that this manifestation of information asymmetry is one of the most pervasive market failures in health care market, and is at the heart of the many challenges outlined in its submission²⁵.

- 4.24 The submissions of Discovery Health, Medscheme and Metropolitan Health support this. Discovery points out that while asymmetry of information and supplier induced demand are not problematic per se, where health professionals (or other suppliers of healthcare goods and services) stand to benefit financially from their treatment decisions, these features of healthcare markets can lead to the use of higher volumes of and/or more expensive healthcare goods or services than might be strictly necessary from a clinical perspective. To the extent that these patterns of 'excess' consumption relative to true clinical need do occur, they will increase the costs of healthcare.
- 4.25 Medscheme states in its submission that residual medical inflation could be reduced if information asymmetry is addressed. Regulatory change to oblige publication of healthcare cost and quality outcomes will allow greater transparency and therefore empower beneficiaries to purchase more cost effective care. This should be facilitated by the establishment of a central coding authority to manage coding and set an industry reference price list. It is Medscheme's position that regulatory change to enable mandatory publication of fees, cost and quality of healthcare services will create transparency and consequently greater competition based on quality healthcare outcomes. BHF supports Medscheme's position.
- 4.26 BHF agrees with the statement by MSD that not all patients achieve the desired therapeutic outcomes on the scheme recommended treatments and that schemes should make provision also for these patients, which appears to not always be the case. BHF disagrees with the submissions of Transpharm and MediRite that price regulation in the pharmaceutical sector, has caused the cost of medicines in the private healthcare sector to be significantly higher than the costs of the same medicines sold to the State.
- 4.27 BHF submits that the cost of medicines to the private sector has always been higher than the cost of medicines sold to the State even prior to the promulgation of the medicines pricing regulations. BHF believes that the price of medicines in the private sector should

be the same as the price of medicines in the public sector and that price differentiation on this bases makes a mockery of the notion of competition in the private health sector and within the health sector as a whole.

4.28 BHF supports the caution issued by Johnson and Johnson in its submission against unintended consequences arising from ignorant and unsystematic attempts by organs of state to regulate the private health sector. BHF fully endorses the principle stated in the Johnson and Johnson submission of equitable access to essential medical products, vaccines and technologies of assured quality, safety efficacy, cost-effectiveness and their scientifically sound and cost-effective use.

4.29 BHF also supports Johnson and Johnson's arguments against the concept of designated service providers. What should preferably happen is that the patient chooses his or her service provider and informs the medical scheme of his or her choice. The patient must then make use of the services of the selected service provider. This promotes continuity of care, reliability and continuity of patient data and consistency in the treatment of patients. It also contributes to the prevention of fraud by providers, encourages providers to compete on the basis of quality of care and prevents abuse by patients of prescription medicines.

4.30 BHF supports Johnson and Johnson's argument that regulation of the private health sector should always be focused on health outcomes. The system as it is currently is too fragmented to successfully focus on let alone assure quality health outcomes. Patient's must have access to the most appropriate care and the most appropriate health care providers, appropriateness being determined by pre-determined and desired health outcomes and not competition.

4.31 The burden of the public health sector upon the private health sector is once again emphasized by the admission in Johnson and Johnson's submission that the price of medical devices is influenced inter alia by public sector debt. In some cases accounts are outstanding for more than 3 years. This is yet another example of how the public sector is indirectly subsidized by the private health sector and why the Competition Commission's Inquiry cannot ignore the public health sector when considering the private health sector.

4.32 BHF highlighted some years ago the exploitation by private hospitals of the small distributors of medical devices in demanding rebates which exponentially increased the cost of medical devices to the consumer. Despite extensive publicity no meaningful corrective action was taken by the relevant authorities.

5. *Medical Schemes*

5.1 It must be noted that many medical schemes did not make submissions of their own to the Inquiry. BHF wishes to point out that one of the reasons for this is that some medical schemes, especially the smaller ones, are afraid of victimisation by providers of health care services, especially the hospital groups.

5.2 BHF supports Discovery Health Limited's proposal that a risk based capital approach to medical scheme solvency regulation should be investigated and implemented as soon as possible. This would address the problems of the current 'one size fits all' approach that forces all schemes to hold 25% of gross premiums in reserves. It would allow large and stable schemes to hold less reserves, and would ensure that members of smaller schemes which require more than 25% in reserves are adequately protected. In this context BHF agrees with Discovery that a revision is necessary of Annexure B of the regulations to the Act, which constrains how schemes may invest their assets, resulting in suboptimal investment returns.

5.3 BHF also supports Discovery's contention that while a Risk Based Capital approach is being investigated, consideration should be given to changing the current requirement that the 25% solvency requirement be applied to gross contributions including personal savings account contributions, to a requirement that only risk contributions are included in the solvency calculation. There is no rationale for a scheme to hold an additional 25% of savings account premiums, as a member can never claim more than their total annual savings premium, and no risk is carried by the Scheme in respect of member savings.

5.4 BHF submits that mandatory membership of a medical scheme for all persons earning above a certain threshold income is an essential but missing piece of the puzzle in addressing the high costs of private health care in South Africa. Adverse selection is rife and there is little that medical schemes can do about it due to the legal requirements of open enrolment, community rating, the prescribed minimum benefits and their hospicentric focus, the absence of a risk equalisation mechanism and the recent growth

spurt in medical insurance schemes that deceive the public and encourage adverse selection against medical schemes.

5.5 This is supported by the submissions of Discovery Health Pty Ltd. The latter states in its submission that over and above the fact that those who are diagnosed with a chronic condition are more likely to remain on a scheme relative to non-chronic members, there is also adverse selection by members diagnosed with a chronic disease, who only join a scheme once they are diagnosed. Discovery states that a concerning trend that can be observed in all the graphs, is that the percentage of first year members who claim is significantly higher than for members who have been on the scheme for a longer period. This shows a high degree of adverse selection. The benefits for a non-member to join a scheme when diagnosed with a chronic disease significantly outweigh the premiums that they would have to pay, despite the 3 month waiting period and possible Late Joiner Penalties imposed on the premiums.

5.6 Even employees of the Competition Commission have in their personal capacities acknowledged that information asymmetry in the health care environment gives rise to moral hazard and that the consumer is ill informed and not in a position to shop around for the best services and prices offered²⁶. They state that 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 quantities of healthcare goods and services if there are no limits to the amount of funding they receive for treatment.

5.7 BHF agrees in principle with the submission of Discovery that the scope of the current specialist and hospital focused PMB list should be reduced to those conditions that are truly required to provide scheme members with protection against serious medical conditions; and that a defined package of primary care PMB treatments should be introduced. These new primary care components of a PMB package should not add to the total cost of PMBs. The PMB benefit package should be designed based on addressing health needs and promoting access to care.

5.8 As pointed out previously certain reforms were planned by government concerning medical schemes but were only partially executed. Mandatory membership remains unrealised. As a result medical schemes are in some ways over regulated without the means to protect themselves from the risks associated whether directly or indirectly with such regulation. Open enrolment in an environment where membership is not mandatory is

an invitation to adverse selection for example. The same can be said for community rating in an environment in which there is no mandatory membership since the cross subsidisation and social solidarity principles upon which medical schemes are supposed to operate are undermined.

5.9 BHF strongly supports Discovery's and Medscheme's recommendations that a collective negotiation process between schemes, administrators/MCOs and representatives of health professionals for the maintenance and upgrading of coding be investigated and implemented and that this process should involve collective negotiations in relation to actual codes, the description of codes, and the relative value unit of codes. Medscheme recommends that an independent, multi stakeholder coding authority should be created to develop and maintain coding structures for all provider disciplines, standardising procedural codes within the industry.

5.10 As part of this, clear descriptors of codes should be provided, detailing the scope of each code, i.e. what is and what is not covered, as well as which provider type is qualified to use a certain code. Rand Value Units (RVU's), indicators of the relative value of procedures in terms of input time, relative risk, and training required, should furthermore be defined. Without such standardisation, patients are exposed to financial risks and providers and funders alike are burdened by administrative inefficiencies. Medscheme proposes that the Competition Commission, as a matter of urgency, acknowledge that collaboration on a standardised coding framework and definition of code-specific RVUs is not a contravention of Section 4. The clinical nature of such interaction, which is distinct from negotiations aimed at agreeing on specific prices, should be endorsed.

5.11 BHF also supports in principle, Discovery's recommendation that a system of collective negotiation of tariffs for health professionals, should be considered and investigated but does not support the suggestion that these negotiations should be limited to be prescribed minimum benefits only. Unlike Discovery, however, BHF believes that a tariff system should be available to cover all health benefits offered by medical schemes and does not accept the arguments Discovery makes to the contrary that the inclusion of all health care services in such a tariff system would facilitate collusive practices among health professionals, damage competition and contribute to tariff inflation. BHF submits that if only PMBs are covered by a tariff system, there will be a temptation on the part of providers to diagnose outside of the PMB tariffs in order to be able to charge higher rates and gaming of the private health care funding system will continue unabated except in

reverse. Currently providers have an incentive to diagnose conditions so as to fall within the PMB package because it is to their financial advantage to do so.

5.12 BHF supports Discovery's recommendation that health professionals should be required to provide schemes with a minimum clinical dataset, including radiology and pathology results and hospital summaries. There is a singular lack of data within the private health sector due to an overemphasis by health care providers on the patient's rights to privacy and confidentiality and in defiance of the provisions of section 15 of National Health Act 61 of 2003 that a health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user. Sharing clinical data will help with quality of care assessment – an essential element of health governance.

5.13 In the private health sector, variety is not the spice of life when it comes to tariffs. Medical schemes and their members do not want to pay differing rates for the same services, they want to pay the same fair and reasonable price for the same services. This is called the principle of social solidarity. Morally and ethically there is no justification for charging patients on different medical schemes different rates for the same services purely because of the difference in their medical scheme membership. Medscheme points out in its submission that the absence of reference prices has resulted in doctors quoting different consultation fees and different procedure fees for different medical schemes and sometimes even for the different options within schemes²⁷. The notion of unequal bargaining power on the part of medical schemes is problematic in an environment where access to health care services is a constitutional right. Competition between medical schemes is an overrated concept.

5.14 What can possibly be the justification for the members of one medical scheme subsidising those of another because the "bargaining power" of the first scheme does not equal that of the second? BHF here wishes to emphasize the important point made by the Department of Health in its submission²⁸ that:

"It is noted with concern that the Inquiry Statement of Issues identifies Access, Affordability/Costs, Quality and innovation, as outcomes of interest, but excludes any explicit reference to Equity and Appropriateness. Most importantly it is not clear from the Statement of

Issues that the Inquiry appreciates that the outcome of interest is health, including health protection, promotion and improvement for *all South Africans*" (BHF's italics)

and that²⁹:

"Equity is a normative notion, and is at technical odds with traditional economic theories of efficiency, and efficient resource allocation. For example, mainstream approaches to economic efficiency dictate that maximising the desired outcome (health, in this instance) for available resources, requires that investments flow to wherever the greatest capacity to benefit exists. There is no concern regarding the equitable distribution of benefit. *This conflict with standard economic theory, and thus standard principles of competition, must be borne in mind.*" (BHF's italics)

5.15 Medical schemes do not have much control over the members they attract – even open medical schemes have very little control due to the legal requirement of open enrolment. They have to accept whoever applies for membership. Restricted membership schemes do not compete with each other due to their nature. According to Discovery Health's submission, restricted schemes do not compete with each other for beneficiaries, because they are restricted to specific employers or industry groupings.

5.16 Restricted schemes do not generally compete with open schemes. Competition between restricted membership schemes and open schemes is largely notional since restricted membership schemes are usually employer group based. If the employer or employer group decides not to support a restricted membership scheme it is usually because they have decided it is too much trouble to maintain it and they would rather focus on their core business which has nothing to do with medical schemes. In this scenario the restricted membership scheme is usually shut down.

5.17 Restricted membership schemes are not commercial businesses. They do not sell commodities. They do not have customers who "vote with their feet". They are a not for profit vehicle for the financing of health care services for their members. Their members are very often contractually obliged by their employers to belong to the restricted membership scheme. This is not only true of restricted membership schemes. Employers will often contractually oblige employees to belong to an open medical scheme of the employer's choosing. (According to Discovery Health, 70% of Discovery Health Medical Scheme members join through employers.) This is because historically membership of a medical scheme was an employment benefit.

5.18 The first medical schemes were established by employers in order to assist and attract employees. Historically medical schemes were never conceived of as business or commercial enterprises. Much of that character remains in the medical schemes of today. Open membership schemes are a comparatively recent development and largely the result of medical scheme administrators' efforts to increase their administration fees and thereby their profits.

6. *Other comments*

6.1 With regard to SAMED's submission, BHF notes that the letter dated 1st December 2014 does not deny the perverse practice of rebates by its constituency. Its willingness to assist the panel is welcomed.

6.2 BHF notes with regard to the Physiotherapists' submission that benefit design, while not perfect, must not be conflated with an unwillingness to pay for services. Most outpatient services benefits are structured with limits or savings. PMB considerations are different.

Conclusion

BHF would be happy to clarify or elaborate on any points made in this submission should the Competition Commission require it and once again thanks the commission for the opportunity to make this submission.

¹ See Mediclinic's submission at page 27

² Netcare submission at page 11

³ Netcare submission at page 25

⁴ See Netcare's submission at pages 26-27

⁵ See Netcare's submission at page 29

⁶ See Netcare's submission at page 33 and also at page 36

⁷ See Mediclinic's submission at page 12

⁸ See also Profmed's statement on page 7 of its submission that scheme size does matter and that small to medium schemes do not have negotiating power with service providers as a result of the oligopolistic nature of the hospital industry, shortages in certain medical specialist disciplines and the unrestricted guaranteed payment for prescribed minimum benefits.

⁹ See Bestmed's submission at page 4. See also its statement on page 6 to the effect that smaller medical schemes have diminished bargaining power vis-à-vis health care providers when they seek to negotiate more affordable and sustainable rates. See also Profmed's submission under Tariff Negotiations at page 7

¹⁰ See the submission of Metropolitan at page 15 where it is pointed out that even in the absence of market concentration, hospitals typically serve populations in close proximity to the hospital, provide services in

- relation to perceived emergencies and high need which results in inelastic demand and therefore have considerable market power.
- 11 See the submission of Profmed at page 16. BHF does not agree with the claims of Profmed about the so-called “administrator model” to the effect that the administrator effectively controls and manages the scheme and that the Board of Trustees and the Principal Officer are not independent of the administrator. The fact that Profmed may once have experienced a controlling administrator that acted illegally in terms of the Medical Schemes Act should not create a presumption that all administrators ‘control’ and ‘manage’ the schemes they administer in contravention of the Act. On page 6 of its submission Profmed agrees that the Medical Schemes Act requires that an arms-length relationship should exist between administrators and medical schemes.
- 12 See for instance the submission of Medscheme discussing the Herfindahl–Hirschman Index in relation to the hospital groups in South Africa on pages 59 to 60.
- 13 See paragraph 25 of NHN’s submission which states that it is “practically not within the mandate of medical schemes to contract on a local level with single entity hospitals except on an ad hoc basis where exposed to such health establishment due to the location and utilisation thereof by its member”. This paragraph apparently contradicts the statement in paragraph 22 that medical schemes tend not to negotiate with individual health establishments on an ad hoc basis.
- 14 See the submission Profmed at page 6
- 15 See Life Healthcare Group’s submission on page 6 where it states that LHC would argue that changes in utilisation have had a much more significant impact on expenditure on hospitals than any pricing effects. Whilst some might seek to attribute the observed growth in utilisation of hospital services on intentional over-servicing on the part of hospital groups in particular, LHC would argue that the trends observed in this regard are due to systemic challenges within the sector, in particular from both a demographic and regulatory perspective.
- 16 Section 57(3)(a) of the Medical Schemes Act
- 17 As the Medscheme submission indicates at page 61 the HHI concentration of private hospitals is far higher than that of medical schemes
- 18 Higher payments for ICU, HCA and theatre in order to move to net acquisition pricing – see BHF’s submission in this regard.
- 19 Page 11 of the Department of Health’s submission.
- 20 Kumar, Ankit, et al., et al. Pricing and competition in Specialist Medical Services: An Overview for South Africa. Paris : OECD Publishing, 2014. OECD Health Working Papers.
<http://dx.doi.org/10.1787/5jz2lpxcrhd5-en>.
- 21 See Medscheme’s submission at page 74
- 22 IPAF correctly points out in its submission on page 12 that in Australia, the GPs’ role as care coordinators is absolutely enforced in the private and public sector. Patients may not be admitted to hospital or see specialists without GP referral and it appears to work very well in containing downstream costs.
- 23 See the ICPA submission on pages 3 and 4.
- 24 Regulation 8(2)(b)
- 25 See the submission of the National Department of Health at page 22
- 26 Pamela Halse, Nonkululeko Moeketsi, Siphon Mtombeni, Genna Robb, Thando Vilakazi And Yu-Fang Wen ‘The Role of Competition Policy in Healthcare Markets’
- 27 See Medscheme’s submission at page 20
- 28 See the Department of Health’s submission at page 14.²⁹ See the Department of Health’s submission at page 17