COSATU

PRESENTATION TO THE HEALTH MARKET INQUIRY, COMPETITION COMMISSION

18 February 2016

CSIR International Convention Centre, Tshwane

Contact:
NEHAWU Head Office: 011 833 2902
COSATU Head Office: 011 339 4911

1 INTRODUCTION

1.1 We are from NEHAWU, a leading health union but it is an even bigger honour to make this presentation because we are representing and speaking on behalf of the 1,9 million strong membership of COSATU. Many of these workers, especially those employed by the private sector do not have any medical insurance. But still, those who may be medical scheme members come from households - for which they are responsible of their welfare - that do not have any kind of medical insurance. Therefore, we are giving expression to concerns of the broadest section of the working class and the poor. Nonetheless, our underlying motivation in this exercise is that we believe that many of our members who are members of the medical schemes are part of the population that is on the receiving end of price-gauging and rent-seeking that is prevalent across the "value chain" of the private health industry.

1.2 We have welcomed the establishment of the Health Market Inquiry (HMI), even though we have been concerned as to the implications of its outcomes given the fact that this takes place under the auspices of the Competition Commission. In part, this is because in our view the 2004 ruling on collective bargaining between providers and schemes may have arguably exacerbated the rise in private health care costs and it appears as if this issue would not even be under consideration in terms of the Revised Statement of Issues (RSOI).

1.3 In this input we do not rehash some of the points made in our original submission. Instead, we deal with some of the key points and in a process we simultaneously respond to some of what is in the RSOI.

2 CONTEXT

2.1 It is necessary to state at the outset that our approach to the inquiry into the high private sector health costs is informed by our starting point – that health insurance is a critical component of social security within an even larger context of a comprehensive social security. It is therefore not yet another business sector for profit maximisation. It is our understanding that despite the advances that have been made towards the direction of a comprehensive social security in South Africa since 1994, in the overall the reforms that have taken place have been

at best a patchwork of piecemeal and disjointed efforts that could best be described as parametric. In other words, these reformist efforts have largely been tinkering with what has been inherited from Apartheid with the view to expand access within the model that is largely suitable for a highly racialized and unequal order. Hence, the outcomes of the path-dependency of these reforms have yielded outcomes that are still significantly marked by features of the past. This includes what we regard as a failed attempt to introduce social health insurance in the late 1990s, of which private health insurance was seen as a key element.

2.2 Viewed in an international context, in our view this runs counter to the basic principles of social security that emerged especially after World War II, in which universal access and solidarity are the cornerstones. The wave of Neoliberalisation that started over four decades ago, in which privatisation of health and retirement insurance were the hallmarks, that swept mainly the countries of the global-south has passed its peak in the light of the fact its outcomes have generally been the exact opposite of what social security is set out to address and achieve.

2.3 Hence, lesson have been learned as underscored by the 2008 report of the World Health Organization, which identified commercialisation as one of the key factors which prevents nations from reaching their health policy goals. It states that:

> "commercialisation has consequences for both quality and access to care. The reasons are straightforward: the provider has knowledge; the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient".

2.4 The point we are making here is that some of the issues identified by the RSOI as "distortions" or "failures" are actually typical, objectively inherent and systemic – and therefore not necessarily abnormal at all. Our submission cited an example of the United States as described in the work of the Robert Wood Johnson Foundation (2014) which estimates that the number of uninsured in that country could jump to as much as 65 million in 10 years as health care costs double. We are yet to see the progressive but still inadequate measures introduced in terms of the Affordable Care Act (Obamacare) passed in 2010. Hence, as a poor mirror-image of the US private health system (RWJF Survey:

2013), for us it is not surprising that private health care in South Africa is expensive relative to the country's wealth, a fact which is also confirmed by the OECD (2015) in a paper that states that private hospitals in South Africa are least affordable when compared to OECD countries even for individuals of higher levels of income. Thus, regrettably missing amongst the issues for consideration in terms of the RSOI is a relevant international comparative analysis with regard to the costs of private health insurance systems in their different configurations.

2.5 Whilst there may be an appreciation that access to health services and care is a constitutional socio-economic right, the approach taken by the HMI within the framework of the "theories of harm" appears to us to straightjacket this inquiry within a Neoliberal paradigm. Hence, even the discursive language of the RSOI is heavy with the often inaccessible and problematic Neoliberal jargon that even refers to sick people as "markets", "consumers", etc. Therefore, for some of us whose ideas and assertions fall outside this paradigm that envisages remedial measures to correct market distortions and failures that are seen as abnormal, we are weary as to the value of our submission.

3 OUR KEY ISSUES AND THE REVISED STATEMENT OF ISSUES

3.1 According to the HMI, the remit of this inquiry is by and large narrowly focused on determining whether or not there are features of the private healthcare sector that undermine competition. Nonetheless, we note that the scope has been broadened beyond what the HMI states as the task of this exercise. It may be logical and we certainly support this, but we are concerned that the broadening of the scope leaves out some of the key and actually obvious considerations in this inquiry. In our view, this is because of the prevalent ideological paradigm of Neoliberalism that looms so large in the RSOI.

3.2 The HMI states that the RSOI outlines its "current thinking" even though it is also saying that it is still "presently in the investigative phase". Therefore if it is said that the statement highlights issues that are currently considered "as priority focus areas of the HMI going forward," then in this presentation we seek to critique the approach taken on some of the issues, to raise issues that appear to have been ignored or

not considered as priority issues going forward, whilst at the same time we emphasise some of our original assertions.

Risk-pooling failures

3.3 The RSOI seems to appreciate that risk-pooling failures are common to all private healthcare systems. In other words, they are structurally objective and systemic where health is secondary to the primary motive of profit maximisation. Yet it appears as if the RSOI seeks to revert in its investigation back to a discussion on mechanism such as the risk-equalisation fund or reinsurance arrangements pool.

3.4 We have a fundamental concern about this discussion about possible measures such as risk-equalisation fund because there appears to be no appreciation of the context of this inquiry, i.e. a transition to universal health coverage in the light of the White Paper on the National Health Insurance. This is the direction that the country is taking on the back of the failed attempts to introduce a social insurance model in the 1990s. In our submission we quoted the Minister of Health, Dr Aaron Motsoaledi, saying that the "artificially high private health-care costs need to come down as one of the two major conditions necessary for the successful implementation of the NHI". This is the context of this inquiry and therefore, reverting to social health insurance model would be of little value in terms of the long-term trajectory of the reforms that are underway.

3.5 We would have no concern if there was also a discussion on how to address the high costs of private health sector in the context of an environment of a single payer. In this regard some valuable international experiences could also be drawn from. Therefore, for us it is extremely problematic that the RSOI appears to be indifferent or oblivious to this looming context of a move towards universal health coverage, yet it begins to revert back to a discussion on social health insurance as it broaden its scope of inquiry. Therefore, whilst we think that a discussion on "the failure of Government to implement social health insurance arrangements" may be part of some explanation but actually it is an irrelevant discussion in terms of where the country is trying to move towards.

Market power and concentration

3.5 We welcome the fact that the issue of market concentration in the private healthcare system across the spectrum of medical schemes, administrators, hospital groups, pathology firms and others has been identified as one of the key issues of investigation according to the RSOI. Indeed there is an appreciation that "as market consolidation increases, the risk of anti-competitive conduct through the exercise of market power increases." In our submission we have alluded to a number of studies that confirm this, including by McIntyre and Gilson (2002), DBSA (2008) and Econex (2013). The study by Econex identified four key factors as primary causes of the increasing private costs:

- the acquisition of beds,
- expensive technology,
- concentrated ownership, and
- commercialisation.

3.6 Some of these have been substantially canvassed in the RSOI, therefore there is no need to deal with them here. However, we are concerned that the RSOI seem to suggest that the HMI would merely "consider the consequences" of the concentration and thus disregarding the causes. Therefore, it would appear as if the question of the objective structure of this industry across the board would be entrenched, whilst some remedial measures directed at the subjective, behavioural or market conduct would be the only area were some solutions would be forthcoming. This then to us apparently rules out the question of the restructuring or breaking up of concentration in terms of the investigation of the HMI. Therefore, we would like to reassert that the prevalence of oligopolies across the value chain is a fundamental problem that must be addressed, from which the issue of the market conduct (especially with regard to the hospital group sector), is a necessary by-product given the prevailing *de facto* deregulated landscape.

3.7 The Department of Health (DOH) reports that the private hospital market in metropolitan areas, which caters for more than half of medical scheme population, was concentrated by 1999.[1] Thus, accordingly between 1998 and 2000 a significant change in terms of

[1] This is from a presentation by the Minister of Health, Dr Aaron Motsoaledi to COSATU on the 10th November 2015.

concentration in ownership in the private hospital landscape took place. This sharply coincided with the escalation of the private hospital costs in real terms and since, in terms of the 2009 prices. Similarly, this also sharply coincided with the escalation of returns on investment for the hospital groups.

3.8 We have cited the report by Genesis Analytics which documents an analysis of the return on capital employed (ROCE) in the South African operations of Mediclinic and Netcare — the two largest groups. It analysed ROCE before and after 2001. Accordingly, between 1988 and 2001, Mediclinic's average ROCE was 14%. Between 2002 and 2011, ROCE had increased to 23%. Return on capital for Netcare averaged 15% between 1997 and 2001. Between 2002 and 2011, that number had jumped to 22%. We welcome the fact that the RSOI identifies the issue of profit rates for investigation.

3.9 Thus, from our point of view, we want to underscore the point that merely focusing on behavioral market conduct, whilst leaving the existing giant monopolies intact, of which the market conduct is a by-product, would place the outcomes of this exercise into question – even from a point of view of Competition Commission. We believe that the fact that the mergers that have taken place have been approved by the commission's Tribunal may account for this.

Overcapitalisation in terms of beds

3.10 Alongside the over use of expensive technology as noted in the RSOI, it is necessary for us to emphasise overcapitalisation in terms of beds. We draw this from the study by the Development Bank of South Africa (2008) which identifies the increased acquisition of beds as one of the factors contributing to the escalation of costs, which we think must be considered. Accordingly the private sector had a bed over-supply of 10 000 by 2008, as a result of adding 4 000 beds between 2004 and 2008. It may be unclear to us as to the situation in this regard presently, but this is a matter that must be taken into account in the inquiry.

Outsourcing and concentration in administration

3.11 Related to this question of concentration, we would also like to underscore our concern with regard to administrators of schemes in a

manner that has not been considered in terms of the RSOI. This pertains to not only the question of concentration with regard to administration in medical schemes but equally importantly, the correlation of the outsourcing of administration and higher costs.

3.12 In this regard, we base our analysis on the 2013/14 Report of the Council of Medical Scheme, which was the basis on which we had to mount protest marches on the 3rd October 2014 as NEHAWU. Accordingly, we found that in 2013 the self-administered open schemes experienced an increase of 3.0% in the cost of administration and managed healthcare services - from R128.4 in 2012 to R132.2 in 2013 in terms of per average beneficiary per month (pabpm) whilst those open schemes that have outsourced their administration experience a 6.8% increase (from R139.0 in 2012 to R148.4 pabpm in 2013). Thus, effectively, the out-sourced or third party-administered open schemes paid 12.3% more for administration and managed healthcare services than self-administered open schemes.

3.13 Similarly during 2013, there were eight self-administered restricted schemes representing an average of 281 489 beneficiaries and 59 third party-administered restricted schemes, representing an average of 3 665 319 beneficiaries. Those with outsourced or third party-administered restricted schemes spent an average of 37.2% more on administration and managed healthcare management fees than their self-administered counterparts.

3.14 The point we want to underscore in this regard is that it is obvious that outsourcing of administration has a clear influence in the escalation of the non-health care costs. Therefore, this is a matter that requires an investigation by the HMI as it also relates to the dynamics of the market structure of administration in schemes. This is apart from the fact that from our point of view, outsourcing deepens inequalities in our society given the fact that it is often the terms and conditions of workers that become the basis of the competitiveness of the companies involved and thereby their domination in the area.

External factors

3.15 The HMI identifies the question of the nurse salaries amongst what are calls external factors that are apparently "beyond the control of

market actors", contributing to the adverse market outcomes. In this regard, public sector salary increases are blamed for the rising costs in the private sector, despite the fact that there has been considerable rise in profits accumulated by the hospital groups as alluded to in the foregoing in term of the report of Genesis Analytics (2012), and cited in our submission. It goes without saying that this reflects the views of the private health employers.

3.16 From our point of view, underlying this is the fragmented two-tiered health system in South Africa. The fact of the matter is that pay in the private sector is better than in the public sector. Thus, rather than this being an external factor beyond their control, the private sector itself deliberately ensures that this to be the case so that there could be drainage of medical workers from the public to the private sector. Hence, we concur with the White Paper when it says that on the contrary:

> "High costs in the private health sector also contribute to high costs of labour in the public sector as the public sector attempts to match the high salaries in the private sector".

3.17 Therefore, we would argue that the investigation by HMI must rather focus on the relationship between pay of the nurses and what appear to be run-away profits rates in the private sector.

Regulation

3.18 We note that HMI recognises the need for regulatory interventions, but with a view that this would create a "normally" functioning private health market. On our part we support such interventions that are necessary in the absence of a single-payer to the extent that they would help reduce the high costs in private health care. Hence, we argue that in the interim the DOH must reintroduce the National Health Reference Price List (NHRPL). We believe that the court ruling abandoning the published 2010 NHRPL did not in any way prevent the department from following the correct procedure and re-establishing the NHRPL.

3.19 The other regulatory matter that we wish to draw to the attention of the HMI relates to what we consider to be self-enrichment that is taking place in the boards of trustees of medical aid schemes, particular in

the Government Employees Medical Scheme (GEMS). For example, in 2012 according to the report of the Council of Medical Schemes the average annual "stipend" of each of the trustees of the top 10 medical aids was R270 000 which translated to approximately R23 000 per month. Whilst the 2013/2014 Annual Report of the Council of Medical Schemes shows that GEMS has spent an average "stipend" of R568 000 per trustee, totalling R7 951 000. This is taking place at the time when GEMS, like other medical aid schemes that have outsourced their administration, have seen costs rising at double the rate when compared to schemes in which administration has been kept in-house or in-sourced. This is part of the rising non-health costs taken away from every rand of a member's contribution and so we propose that this matter must be looked into by the HMI and appropriate remedies recommended.

4 CONCLUSION

4.1 We have expressed our concerns with regard to the overall thrust of the inquiry which appears to disregard the context of the move towards universal health coverage and single-payer, a move that is in keeping with the principles of social security, including our constitution's injunction in terms of section 27.

4.2 We do appreciate that this inquiry is taking place under the auspices of the Competition Commission, and therefore necessarily it is focused on determining whether or not there are features of the private healthcare sector that undermine competition. We are convinced that some of the "distortions" and "failures" identified are inherent and systemic in the contemporary capitalist markets, especially regarding the question of market power and price-gauging. Retirement insurance is another form of privatised social security that reflects remarkably similar characteristics not only in South Africa but also in the other parts of the world where there is a prevalence of private arrangements.

4.3 Nonetheless, we do recognise that the HMI has identified some of the pertinent issues afflicting the private health sector in terms of high costs, which we hope its outcomes would go a long way towards finding solutions. These include the exorbitant costs associated with the fee-for-service model, imbalance in tariff negotiations between purchasers

and providers, information asymmetry between patients and providers, small and fragmented risk pools in each medical scheme and others.

4.4 In the time available, we have attempted to respond to some of the aspects of the RSOI and made proposals on other issues that may be considered for investigation even within the prevalent paradigm of the inquiry. We believe that these issues are also influential in determining the current exorbitant costs of the private health care and can be address by the inquiry.

REFERENCES

Council for Medical Schemes Annual Report, 2013-14. Pretoria: Council for Medical Schemes.
Department of Health (2015). National Health Insurance for South Africa: Towards Universal Health Coverage
Econex: Updated GP and specialist numbers for SA: Health Reform Note 7, October 2010.
Harrison D An overview of health and healthcare in South Africa 1994-2010: A discussion document commissioned by the Henry J Kaiser Family Foundation to help inform the national health leaders' retreat, Muldersdrift Jan 24-26 2010
Gilson L & McIntyre D (2007) Are South Africa's new health policies making a difference? Joint HEU/CHP policy brief. Cape Town and Johannesburg, Health Economics Unit and Centre for Health Policy
OECD and WHO (2015) International Comparison of South African Private Hospital Price Levels.
Robert Wood Johnson Foundation: Survey (2013) 5.4 Million Americans Gained Health Insurance Since September 2013
Robert Wood Johnson Foundation (2014) Long-Term Care: What Are the Issues? Issue Brief
Ranchod S, Childs B, Abraham M & Taylor R: International benchmarking of hospital utilisation: How does the South African private sector compare? Presented at the Actuarial Society of South Africa's 2015 Convention 17–18 November 2015, Sandton Convention Centre
World Health Organisation (WHO), The World Health Report 2008 - primary Health Care (Now More Than Ever)