THE SOUTH AFRICAN MEDICAL ASSOCIATION

SUBMISSION TO THE COMPETITION COMMISSION MARKET ENQUIRY INTO

PRIVATE HEALTHCARE

IN RESPECT OF PROPOSED REGULATORY INTERVENTIONS FOR LICENSING OF HEALTH FACILITIES (14 FEBRUARY 2018)

Date: 26 February 2018

1 Introduction

The South African Medical Association (SAMA) thanks the Competition Commission Private Health market Inquiry (HMI) for the opportunity to submit in response to its paper on proposed regulatory interventions for licensing of health facilities.

As a voluntary membership organization, SAMA does not prescribe to its members how or where to practice, but we do remain vigilant of other regulatory changes which could influence the way our members are expected to practice in the country.

Regrettably, the commentary period of fewer than two weeks has been insufficient to put the HMI document out to our membership for comment. Thus, it is entirely possible we are neglecting to address the concerns of practitioners in more or generally rural underserved areas, where competition for services is low.

SAMA recognizes that once again, the HMI comes up against the conflict of enhancing competition, with the need to improve equitable access to services in the country. IN a highly competitive environment for health facilities, barriers to entry and exit would be low, regulation would not impair the ability to enter, and the services offered would differ very little from each other. South Africa's healthcare market does not function competitively.

We commend HMI for considering equity in the distribution of resources. We, however, advance that it is risky to look at one element of health care. In considering licensing of hospitals, we need to look at the following four elements:

a) Competition: competition requires open entry; however, open markets distort the equitable distribution of resources. Supply of health services in open markets is characterised by the ability to pay and availability of health care financing. Licencing according to need, will not result in equitable distribution of resources as maldistributions are as a result of maldistribution of social determinants of Health
b) Equity: It is very noble that health care licencing looks at the equitable distribution of health care facilities. We demonstrate that those in need come from low socio-economic status and lack means to attract the private sector.
c) Efficiency: Often, there are trade-offs between efficiency and equity in health care. Conflicts between equity and efficiency are common phenomena encountered during health policy formulation as policies that are designed to improve operational efficiency

often have the potential to increase health inequalities, or they may improve fairness while challenging efficiency (1)

In 1994, the Government took a position to use Primary Health Care approach to deliver health care services. Therefore, distribution of primary health care clinics and CHC is informed primarily by need. However, hospital care, which tends to be more expensive, tends to take the efficiency approach. The district hospitals are located in peri-urban areas, whilst the secondary hospitals tend to be concentrated in towns and tertiary hospitals in Metropoles and big cities.

Economics tells us the more penetration a supplier has to market, the more efficient they become because of economies of scale. The question we ought to ask is whether market concentration increases the efficiency of private hospitals?

d) Sustainability in health care: Sustainable health care requires innovative interventions that attracts health care professionals, incentivises investors and delivers high quality **affordable** health care to its citizens

SAMA believes that issues of policy/ philosophy and process with regard to licensing must be addressed separately. The equitable distribution of hospitals and underlying philosophies such as Utilitarianism (efficiency approach) and Deontology (rights and justice (equity) based approach) requires careful interrogation.

Processes that are fundamentally inefficient or deficient at the provincial level, limiting approvals of new facilities, must be addressed and improved upon – and we are in support of legislation, which aims to do this.

2 The distribution of healthcare facilities – a global challenge

Distribution of hospital services remains a conundrum, even for high-income societies. (2)

Where the population is more dispersed and distances are greater, access to hospital and emergency services may become problematic. Geographical distance could then lead to inequities in access and underutilization of emergency hospital services among populations in rural or remote areas.

At the same time, there have been pressures to downscale hospital infrastructure, centralize more specialized functions to ensure an appropriate volume of procedures and quality of care, and attempts to move services out of hospitals and into the community. The financial sustainability of small hospitals in rural or remote areas has become a major concern in terms of both capital expenditure and running costs while attracting highly skilled staff to rural or remote locations has posed a further challenge(2).

The distribution challenge is similar to healthcare workers, with only 24% of practitioners worldwide working in rural areas worldwide(3). In looking at regulatory reforms to enhance access healthcare workers in more rural areas, the World Health Organization recommended several regulatory interventions, most of which were incentives, not enforcement:

1. Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.
2. Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas.
3. Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives to increase recruitment and subsequent retention of health professionals in these areas.
4. Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas (3).

Besides incentives to retain health care workers, broad Government rural and peri-urban development programmes such as infrastructure improvement in roads, water, and sanitation, education, and telecommunication are necessary to attract health care professionals and other businesses including private hospitals.

3 Social Determinants of Health and Distribution of hospitals

Social Determinants of Health are the conditions within which people are born and which determine their health status. These conditions determine how long a person will live and contribute to their quality of life. Inequalities in health outcomes are often explained by differences in the distribution of SDH. In South Africa, the following determinants have been associated with access to health care and distribution of healthcare resources.

Inverse Care Law, first defined by Hartman states that that: "*The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced*."(4)

Social Gradient of Disease: According to World Health Organisation, the poorest of the poor, around the world, have the worst health. In South Africa, the evidence shows that in general

the lower an individual's socioeconomic status the worse their health.(5) There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum.

Geoffrey Rose, a well-known epidemiologist argued that the best prevention strategy is to address the causes of causes.(6) A typical example will be that smoking causes heart disease, but the incidence of smoking is higher in people from low socio-economic class. Thus if you address SES status, you will reduce mortality due to smoking by reducing incidence of smoking. Social determinants of health are generally understood to include education, income, living conditions, employment and work conditions, food security, housing, gender race and disability – all of which may render populations additionally vulnerable in some way.

Borrowing from the Social Determinants of Health Approach and Geoffrey Rose, we identify other factors that contribute to the inequitable distribution of hospitals beyond inefficient licensing mechanism.

a) **Inequities in Income a determinant of Healthcare financing mechanism and distribution of health facilities**:

South Africa displays strikingly high and persistent inequality for an upper middle-income country. While GDP growth has averaged a credible 3.2 percent a year since 1995 (1.6 percent per capita), it has been highly uneven in its distribution. In 2013, the richest 10% of the population had 58% of the national income and the bottom 50% shared 8% of the income. (Fiscal inequality report) Gini coefficient increased from 0.59 in 1993 to 0.67 in 2005.
In 2013 Gini coefficient was reported by World Bank to be 0.68. Among the BRICS countries of Brazil, Russia, India, China and South Africa, South Africa has the highest income inequality index, a Gini index of 0.63, and the highest global ranking as the fourth unequal country in the world. Brazil comes second with a Gini index of 0.55 and a global rank of 13.(7).

Challenges in healthcare financing in South Africa have been widely debated and inform the implementation of NHI.

In South Africa, health-care access for all is constitutionally enshrined; yet, considerable inequities remain, largely due to distortions in resource allocation. The health system remains starkly fragmented with private sector serving the only 16% of the affluent population and public sector the rest of 84%.

Simply put, there are sufficient resources in private health care to attract the hospital market. According to World Bank data, in 1995 private sector served 20% of the population vs. 16% in 2003. Compared to 1995 proportion of GDP expenditure has increased from 7.4% in 1995 to 8.9% in 2013. Although public sector's expenditure in health care increased by about 10% since from 1994 to 213, Private Health sector was STILL responsible for lion's share of the NHE – a reduction from 59% market share in 1995 to 52% in 2013.

Although the expenditure in public sector has increased significantly since 1994, there are few public-private partnerships (PPP) in hospitals that are geared to increase access to healthcare by needy high-risk populations not covered by medical schemes.

Examples of needs-based PPPs include Matikwane Hospital in Hazyview and Life Esidemeni. Matikwane Hospital was a joint venture between Gazankulu Government and Private family (report by hospital staff, the initial documents cannot be found) and then later Mpumalanga and Life Healthcare.

The contract between Matikwane Hospital and Mpumalanga Department of Health ended in 2014. Shortly afterwards, there were reports of poor health care which included a parliamentary hearing on the matter in 2017 (8).

The Gauteng Department contracted with Life Esidimeni, to serve the needy mental health patients. The termination of this partnership due to financial constraints resulted in the loss of lives.

Various government initiatives tap into the existing medical schemes population. Folateng is a network of private wards that are set up within Gauteng's public hospitals. Each ward gives the patient the quality and convenience of private healthcare with specialist physicians and innovative technology that only a long-established hospital has the capacity to offer.

Another example is Groote Schuur Private Hospital Partnership. This is an initiative between Groote Schuur hospital, UCT medical school, and Netcare. The facility operates on the same premises as Groote Schuur Hospital. This facility serves medical scheme populations or those with ability to pay. Apart from retaining the skills set within the public sector through remuneration of work outside public sector and training of medical students and Registrars in high technology, other spill over effects of these initiatives on non-paying populations are not clearly articulated.

In 2002, NDOH and Pharmacy Council relaxed the markets by allowing corporate pharmacies to enter the market in an effort to improve equity in health care access.

Later, a study was conducted to assess equity in the geographical distribution of community pharmacies in South Africa in preparation for a national health insurance. Ten years after opening the market to corporate businesses, community pharmacies in South Africa continued to be concentrated in urban provinces. 9) The study demonstrated that the affluent districts have the highest community pharmacy densities. The study confirms that the private health-care system in South Africa is more market-oriented, with the result that areas with lesser need as a function of population size have greater access to medical care. Corporate pharmacies also target LSM 6 to 10 (10).

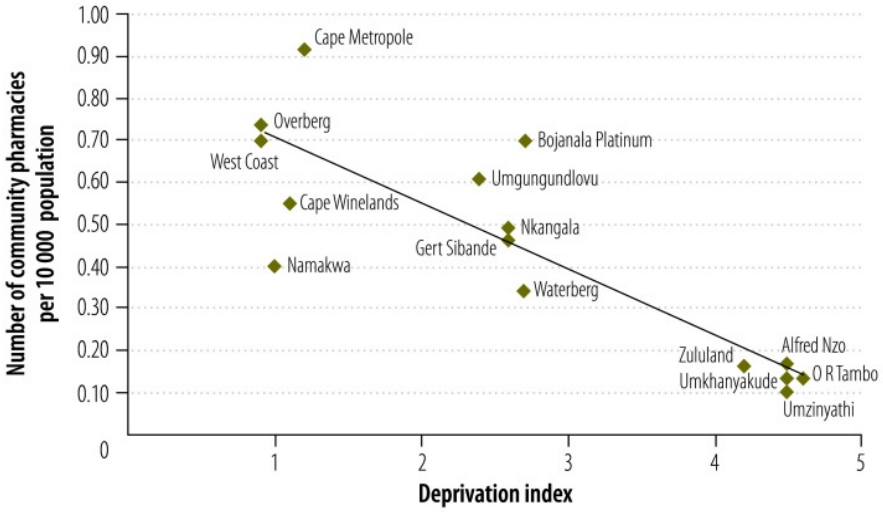

Figure 1: Density of Community Pharmacies by Deprivation Index (9)

The above examples show that needs alone cannot attract the hospital markets into needy and deprived areas, however, availability of health care financing has a potential to address maldistribution. The licensing of hospitals taking into considerations population needs will not address inequitable distribution of health facilities unless the financing mechanism is addressed. By addressing licensing, we are addressing an immediate cause BUT NOT the ROOT CAUSES of the problem.

In section 4 of this submission, we go into details the distribution of facilities in accordance with medical scheme coverage.

b) **<u>Inequity in distribution to hospitals is a result of inequitable distribution of other Social Determinants of Health</u>**

To demonstrate our fact that inequitable distribution of hospitals is as a result of multiple factors we take a closer look at various indices that measure inclusivity and equity in human development.

Inclusive Development Index

The Inclusive Development Index (IDI) is an annual assessment of 103 countries' economic performance that measures how countries perform on eleven dimensions of economic progress in addition to GDP. It has 3 pillars; growth and development; inclusion and; intergenerational equity.

South Africa ranked no. 69 out of the 74 countries (11) indicating that the South African development model was not inclusive. This confirmed that despite increased but slow economic growth, not all Citizens enjoy this growth. Inequitable growth and development could be causing maldistributions in market entry of private hospitals. As the richer continue becoming richer, they have more resources for health care and thus private hospitals are incentivised to even expand health care in affluent populations inefficiently (the cash cow continues providing), through supplier-induced demand.

The Human Development Index

The HDI is a summary measure for assessing progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living.
South Africa's HDI value for 2015 is 0.666— which put the country in the medium human development. However, when the value is discounted for inequality, the HDI falls to 0.435, a loss of 34.7 percent due to inequality in the distribution of the HDI dimension indices. This confirms inequality in distribution in LIFE expectancy, literacy rate, and income.

In conclusion: There is increasing acknowledgment that medical, public health and other regulatory interventions will have limited impact without taking into account social determinants of health. In South Africa, we need to redistribute wealth, education, access to basic living necessities such as clean water and decent nutrition.

4 Distribution of population, medical scheme population and private health facilities in the country

The licensing of private hospitals and other facilities should support and serve the growth of private sector patients, who they are to serve.

Distribution of private hospital beds between provinces is currently similar to the provincial distribution of medical scheme beneficiaries, but not without some discrepancy. The crux of the matter is deciding what the appropriate bed concentration per 1000 beneficiaries actually is – which is not actually such a simple determination.

Assuming the private healthcare sector is an asset to the country, which we would like to see compete with advanced health systems in the OECD countries, and assuming an appropriate number of beds per 1000 of 4.3 (median for OECD Countries in 2016), the following emerges from several collections of data on the provincial split of hospitals in provinces (Table 1).

Table 1: Medical Scheme Beneficiary increases by province from 2006 versus numbers of beds increases (actual and estimated needed 2010 to 2016).

	Medical Aid Beneficiaries 2006(a)	Medical Aid Beneficiaries 2016(b)	Increase in number of beneficiaries 2006 to 2016	Beds 2010 (c)	Beds 2016(d)	Estimated at 4.3(e) beds per 1000 in 2016	4.3 beds per 1000 increase since 2006	Actual beds increase 2010 to 2016
Gauteng	2,593,809	3,479,810	886,001	14,278	17,294	14,963	3,810	3,016
Western Cape	1,157,483	1,309,134	151,651	4,385	6,986	5,629	652	2,601
KwazuluNatal	1,091,744	1,253,144	161,400	4,514	6,962	5,389	694	2,448
Eastern Cape	614,197	638,434	24,237	1,723	2,173	2,745	104	450
Mpumalanga	492,387	545,595	53,208	1,252	1,547	2,346	229	295
North West	365,692	461,237	95,545	1,685	1,587	1,983	411	-98
Limpopo	300,856	412,936	112,080	600	845	1,776	482	245
Free State	341,549	387,739	46,190	2,337	2,321	1,667	199	-16
Unclassified	-	207,996	207,996	-	-	894	894	-
Northern Cape	149,399	179,595	30,196	293	799	772	130	506
Outside SA	20,227	2,461	-17,766	-	-	11	-76	-

(a) Council for Medical Schemes Annual report 2006-2007

(b) Council for Medical Schemes Annual report 2016/2017

(c) South African Health Review 2017 – Health Indicators Chapter

(d) Econex HASA report 2016: The economic footprint of private hospital groups in South Africa

(e) OECD Health Data – Hospital beds per 1000 population. https://data.oecd.org/healthcat/hospital-beds.htm

There appears to have been a disproportionate increase in bed numbers in KwaZulu Natal and the Western Cape. In addition the Eastern Cape and Northern Cape have seen a greater than expected increase in beds, however, it could be argued that they were wholly underserved in 2006 versus the number of beneficiaries on medical aids at the time.

Comparing the provincial distribution of medical scheme beneficiaries and hospital beds in 2016, there is a difference in the proportion of the provincial mix, but this is not dramatic (Figure 1). While looking at the overall population, the distribution of private hospital beds looks extremely skewed towards Gauteng, Western Cape and KwazuluNatal Provinces, when looking at the medical aid covered population groups only, this disparity is less apparent.

As private hospitals are business, and their target market constitutes medical scheme members, it is only logical that there would be a higher number of hospital beds available in larger markets. Setting up a hospital involved significant investment, and unfortunately, as is the challenge globally. Setting up a hospital in an area without the existing or potential patient market to be served, is wasteful and inefficient.

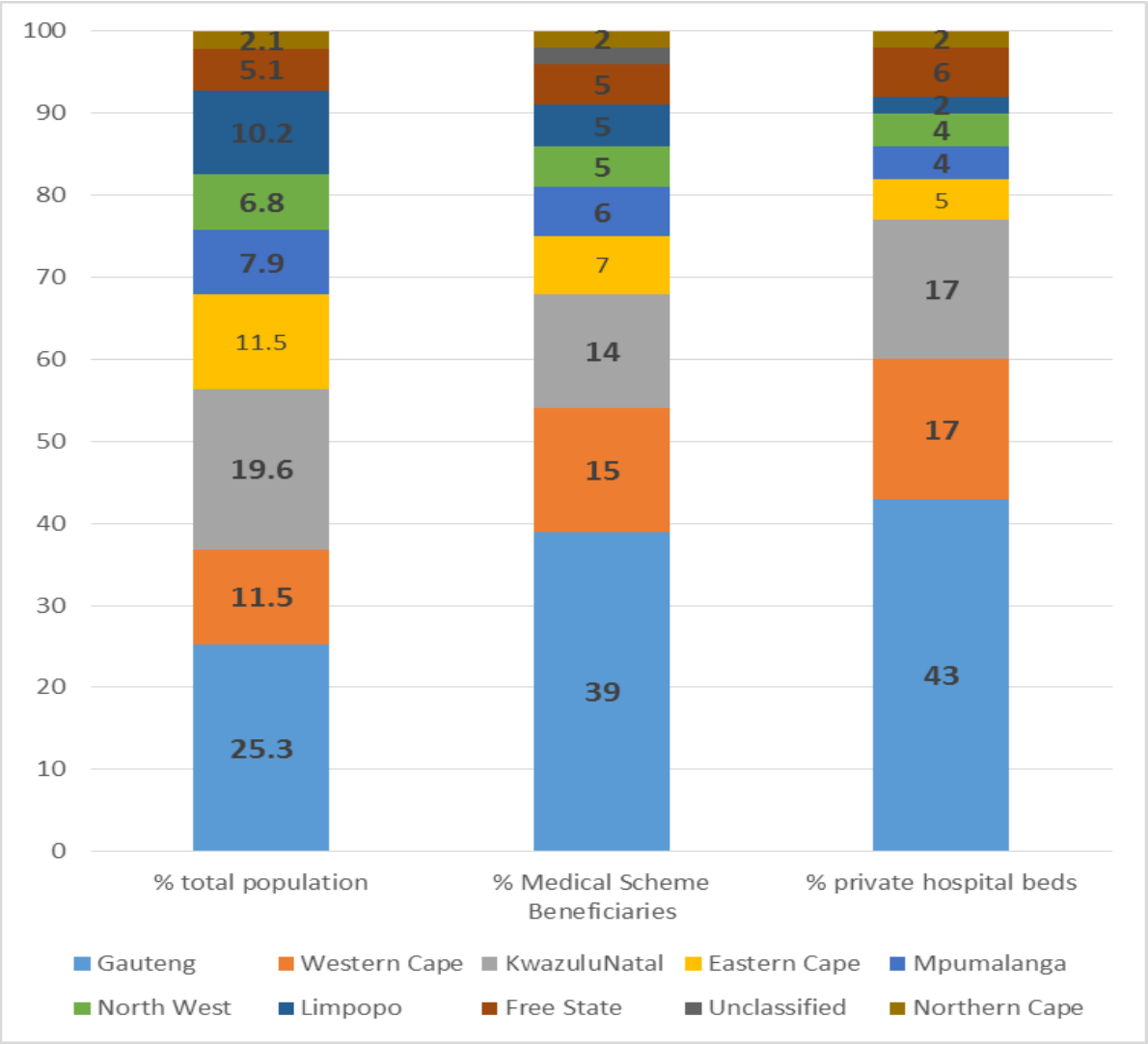

Figure 1: Proportion of the population in each province, the proportion of medical scheme beneficiaries per province and proportion of private hospital beds per province.

5 Processes for license application at provincial level

In the first round of submissions to the HMI in 2014, hospital groups complained about the inconsistencies, long response times, and varying provincial approval processes for facility licensing.

SAMA would be supportive of a standardised, national licensing regime to be implemented by provincial departments, however, only if the national policy reflects the factors/ variables for consideration and does not dictate the quanta involved.
We can only imagine that it would be difficult for a provincial level manager to do the necessary detailed demographic forecasting to determine the need for a private hospital in a particular area.
Provincial Processes also clearly need to be improved, judging by the Mediclinic, Netcare, Life Health and Day Hospital Association submissions to the HMI in 2014.

This was prior to the case in the Bloemfontein High Court in which HASA challenged the Free State Provincial regulations Governing Private Health Establishment No 78 of 2014. HASA believed the regulations were convoluted, poorly drafted and introducing sweeping changes to the manner in which private hospitals and other private health establishments are established and regulated in the Free State Province.

The current Regulations for the Certificate of need actually place the responsibility for this decision in the hands of the Director General of health – which is perhaps even less appropriate than a local decision-maker is.
Section 36(3) requires the *DG to consider several factors in relation to the awarding of a certificate of need – many of which we believe could be contrary to enhancing competition, between private institutions.*

A regulatory regime that offers less inconsistency and less intervention by the National Department of Health would be far preferable.

6 Certificate of Need

The National Health Act, in Section 35, already empowers the Minister by regulation to:

(a) classify all health establishments into such categories as may be appropriate, based on

(i) their role and function within the national health system;

(ii) the size and location of the communities hey serve;

(iii) the nature and level of health services they are able to provide;

(iv) their geographical location and demographic reach;

(v) the need to structure the delivery of health services in accordance with national norms and standards within an integrated and co-ordinated national framework; and

(vi) in the case of private health establishments, whether or not the establishment is for profit or not; and

Section 36 of the Act speaks to the processes for application for Certificate of needs

SAMA also feels the need to address the mentions of the Certificate of need legislation in the HMI discussion document. In 2014, SAMA stood with the South African Dental Association (SADA) and the South African Private Practitioners Forum (SAPPF) against the implementation of the certificate of need regulations.

At the time of the promulgations of the legislation, SAMA was concerned that the Certificate of Need would be wholly incapable, on its own, of improving the equitable distribution of healthcare services in the country.

We felt strongly that the best way to do this would be to improve incentives for healthcare practitioners to work in underserved areas, such as improvement of training opportunities and improvement of living conditions of doctors serving in these areas. We now submit that equitable distribution in healthcare requires not only health policy interventions but identifying and addressing social determinants of Health

The same can be said of health facilities. While a certificate of need process may prevent the opening of services in areas which are already well – served, it is unlikely to mean that hospitals and other facilities will elect to open in deprived areas with high need.

7 Conclusion

The issue of equitable distribution of hospital and similar facilities throughout the country is not a simple one, nor do we believe more stringent regulations on the setting up of hospitals serve medical scheme members, or the general public.

Equitable distribution is a global issue, and generally recommendations are to provide incentives to facilities to serve areas, where services can be offered only in less efficient models, not to enforce legislation to force this on healthcare providers.

SAMA would be in favour of a more transparent and generally applicable licensing regime, which can be applied by all the provinces, according to their own situations and requirements, and we believe the legislation exists for this already.

Forcing private facilities to open in more underserved areas, will likely fail to serve objectives of efficiency, although it may well improve equity in delivery. Should private hospitals and facilities not see value in opening up in underserved areas, however, we could see a decrease in investment completely.

Substantial consideration must be given to the special planning of the different models of licensed facility throughout the country, with consideration for the fact the private facilities cannot be expected to address equity issues in the whole population at this stage.
Where regulations are to be introduced to improve hospital-service delivery to underserved areas, we believe that incentivising rather than mechanisms to try to enforce the development of healthcare infrastructure in these areas will be more successful.

Dr. MJ Grootboom
SAMA Chairperson
26 February 2018

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