Comments on the provisional report of the Competition Commission's Health Market Inquiry

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By Mr Marcus Low

1. This submission is made by me, Mr Marcus Low, in my personal capacity. I am a South African citizen and a member of a large open medical scheme. I previously worked as Head of Policy at the Treatment Action Campaign.

Regarding market concentration in the private hospital industry

2. Market concentration in the private hospital industry is rightly highlighted in the provisional report as a serious problem with implications for competition, prices, and quality of care in the private sector.

3. Such market concentration could however be leveraged in the public interest given the right regulatory framework. This could be done by placing certain special public interest obligations on companies with more than a certain percentage of market share.

4. So, for example, for companies with more than 15% market share nationally there could be a requirement that for every 10 urban beds in the group there must be one rural bed (the ratio should be based on need and may be greater or less than 10/1). Such an arrangement would incentivise large companies to increase rural hospital capacity. Smaller companies would not have to achieve such a ratio. Such a requirement could in effect limit the three dominant hospital groups to expansion only in rural areas for the foreseeable future.

5. Alternatively, it is worth considering replacing rural with "under-served" in the above arrangement. This would however introduce an extra complexity in that an under-served area may no longer be under-served once a new hospital is built there. The extra complexity might well be a worthwhile trade-off though since "under-served" (if properly defined) is a better proxy for need than "rural".

6. A further requirement of hospital groups with market share above a certain threshold could be to require that certain doctor to population and nurse to population ratios be met in rural or under-served areas where they have facilities. In this way, hospital groups themselves will have to create the incentives required to increase healthcare worker numbers in rural areas.

7. Arrangements like the above regarding hospitals and healthcare workers in rural or under-served areas will in the first place improve the availability of services in these areas. It will however also help build the infrastructure and human resource capacity required for National Health Insurance and in this way contribute to the wider realisation of the right to health.

8. Regulations regarding mobile phone call termination rates provide a current example of regulation that treats companies differently because of their size. Broadly speaking, there is thus some precedent for arrangements like those described above.

   Regarding medical scheme transparency and the rights of medical scheme members

9. The report rightly highlights the difficulty scheme members have in accessing information and in electing and holding trustees and principle members accountable.

10. To increase accountability, members should firstly be given more information about their own scheme and secondly about how their scheme compares to others.

11. Schemes should be compelled through regulation to provide members with at least the following information at least once per year in an accessible form (this information should be audited by an entity that is fully independent of the scheme's administrator):

    a. The names of all trustees and principal members together with details of their renumeration and their roles.
    b. Current contact details for all trustees and principal members.
    c. The percentage of scheme funds spent on non-medical costs.
    d. A detailed breakdown of the factors contributing to the previous years premium increase.
    e. An evaluation of the performance of the scheme's administrator that includes estimates of cost-effectiveness and comparison with alternative administrators.
    f. A breakdown of all preferred service- provider agreements together with details of the cost arrangements of these agreements and the rationale for entering into, exiting, or continuing with agreements.
    g. A detailed account of the actions taken to increase value for money for scheme members, including steps taken to introduce alternative reimbursement models.

h. A breakdown of the spending of scheme funds on hospital-based care v non-hospital care, of base package cost v non-base package costs, and a breakdown of spending on medicines by disease area, with cost-driving medicines clearly identified.
i. A detailed, evidence-based motivation for exclusions and inclusions of treatments or treatment areas on all packages that provide coverage supplementary to the base package. This should include annual reports on how and why these packages have changed.

12. In order to allow members to make meaningful comparisons between schemes, an independent body (possibly the CMS) should produce an annual publication in which the performance of all registered medical schemes is compared on a number of key indicators. Some indicators that should be included are as follows:

    a. The cost of the standardised basic package.
    b. Percentage of scheme funds spent on non-medical costs.
    c. Number of members.
    d. Age profile of members.
    e. Renumeration of trustees and principle members.
    f. Scheme reserves (absolute and per member).
    g. If a risk equalisation fund is implemented, an accounting of the fund's impact on each scheme.

13. All schemes should be compelled to offer the minimum package as a stand-alone option. This would allow for better cost comparison between schemes and, together with risk equalisation, for greater head-to-head competition on quality and cost.

14. The number of plans and options offered by schemes should be limited so as to facilitate easier comparison for consumers. In addition to the base package, schemes should be allowed no more than two additional plans.

15. For all plans that provide coverage supplementary to the base plan, all descriptions of the plan should clearly stipulate which elements of the plan forms part of the base plan and which elements are supplementary to the base plan.

Additional miscellaneous suggestions

16. While the proposed establishment of a supply-side regulator is welcomed, such a regulator would be particularly useful if it has a strong research and

quality control function. Ideally, such a regulator would produce regular reports on the quality of services offered by providers – which would include routine data collection from medical scheme members. It is important that such research should be done by an independent body and that its findings should be made public.

17. The supply-side regulator should also conduct research on the use of alternative reimbursement models in South Africa. To facilitate this research, all providers must be compelled to share details of their payment and quality control arrangements with the regulator. The findings of this research should regularly be made available to the public. While the above may seem intrusive, it may nevertheless be one of the least intrusive means by which to push the industry away from a fee for service model, whilst at the same time gathering evidence on optimal payment arrangements. It would also ensure that successful innovations filter through the industry more quickly – thus benefiting consumers.

18. The introduction of a risk equalisation fund is supported since it, together with greater transparency, would force schemes to compete primarily on price and quality.

19. What constitutes a medical emergency should not be determined by coding or by healthcare workers or hospital staff, but by whether a patient had reasonable cause to believe a matter to be an emergency. This would help avoid the unacceptable situation whereby sick or injured patients are told in emergency rooms that they should either make a co-payment or go to another hospital. (I personally had the experience where a card machine was brought to my bed by a member of the hospital's administrative staff who asked me to make a payment while I was both in severe discomfort and sedated.)

20. To increase quality, service providers should be compelled by regulation to routinely provide patients with information on how to lay complaints in a safe and secure way with hospital management, the HPCSA and the CMS.

21. Prior to all planned procedures and subsequent to all non-planned procedures, patients should be provided in writing with the names, qualifications and HPCSA registration numbers of all persons involved in their treatment and care. This is so that (a) patients can be able to know whether the persons providing care are sufficiently qualified and (b) so that patients can have easy access to relevant information should they wish to lodge complaints. In addition to the names and qualifications of all persons, patients

should also be made aware of the contracting arrangements between the various service providers involved in their care.

22. All schemes must give members the option to take part in the election of trustees through a simple online voting system. This should be in addition to existing means of casting votes. This is the only way to ensure more members have the opportunity to vote.

23. During the election process members should also be polled on their views regarding the performance and value-for-money offered by the scheme's administrator. In this regard members will be assisted by more detailed reports on the cost of performance of administrators in reports sent to members (as discussed in point 11.e above) and will also be informed by their own direct experience. If a majority of members express unhappiness with the administrator, this would exert pressure on trustees to either find a new administrator or to negotiate a more favourable contract with the incumbent administrator. The outcomes of such polling should be shared with all scheme members.

24. Savings accounts should be prohibited in regulation since it (a) reduces cross-subsidisation within schemes and (b) complicates the use of benefits for members.

25. There should be no co-payments for services included in the base package, since these should by definition be essential, non-optional services that are generally cost-effective. Co-payments can be permitted for services not included in the base package, since these are likely services of less clear benefit and might include some services of questionable effectiveness. It is not unreasonable to ask private sector users to make co-payments for services or treatments of questionable efficacy.

26. It is imperative that a mechanism should be found by which to regulate the prices of treatments and services, since a co-payment free base benefit package is not viable without some price controls. In this regard the facilitated negotiation process described in the provisional report is supported.

27. A further price-control measure would be to compel hospital groups and other service providers to make full disclosures of their cost and pricing structures ahead of facilitated price negotiations. Such full disclosures would make profiteering and excessive pricing less likely.

28. Hospital groups that (a) fail to come to base package agreements with at least half of all schemes or (b) fail to come to base package agreements with schemes representing at least half of all scheme members should lose their licenses or face other severe sanction. Such an arrangement will change the negotiating balance between schemes and hospitals by forcing hospital groups to enter into at least some agreements with schemes. There should however be an exception to this if during the supply-side regulator facilitated negotiations the medical schemes made demands that were unreasonable given what is known about the hospital's cost and pricing structures.

29. The broker system should be abolished since it pre-supposes and entrenches the information asymmetry between members and schemes. Both schemes and the CMS should instead be compelled to create easy-to-use complaint mechanisms that members can use independently.

    Thank you for the opportunity to comment on this important provisional report.

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