Improved private healthcare sector regulation would benefit the NHI – HMI – Moneyweb 1 October 2019

'For the NHI to succeed, it must come into a stable environment where suppliers and service are regulated' – Dr Ntuthuko Bhengu.

NOMPU SIZIBA: The Competition Commission Private Healthcare Market Inquiry released its findings on the private healthcare sector yesterday, Monday. It found that the sector had been the purveyor of high prices for its clients without necessarily providing the commensurate value. It found that the sector has tendencies that prevent, restrict and distort competition. The findings are not dissimilar to their preliminary findings released last year.

To speak further on the matter I'm joined on the line by Dr Ntuthuko Bhengu, who oversaw the Private Healthcare Market Inquiry for the Competition Commission, and Dr Jonathan Broomberg, the CEO at Discovery Health. Thank you very much, gentlemen, for joining us.

Dr Bhengu, if I can perhaps start with you – the inquiry's findings against the private-healthcare sector are quite damning. You separate your findings into three different sections: around the health facilities, practitioners and medical aid funds. What were your key findings around service providers' conduct among the categories?

DR NTUTHUKO BHENGU: Good evening and thanks for having me. I have to say I'm the chair of the inquiry.
NOMPU SIZIBA: I do apologise.
DR NTUTHUKO BHENGU: The service providers in this regard those would be the facilities and practitioners. We found that from the facility side the market is concentrated, in the sense that Life, Mediclinic and Netcare, the three big hospital groups, control more than 80% of the market, both by number of admissions and the beds under management. In addition to that, I think as explained in the provisional report, which still holds, they don't really compete for patients as such, but they compete to attract specialists. One way of doing that, and certainly the most common way of doing that, is to acquire the most expensive equipment, without a shadow of a doubt and that means there are returns expected and that drives what we call supply-induced demand, which is actually what we are saying – they sort of benefit from that. But the driver mainly is the practitioner.

Now, to put that simply, supply-induced demand is basically where more care is utilised simply because there are more providers to provide it. We do show that the more doctors in an area, the more care you'll get, the better available, the more they'll be used. This is an

issue that is starting to reflect in the manner that new hospitals drive new admissions, even though there isn't a change in terms of illness patterns in an area.

One of the issues of course is that there have been, certainly in terms of price for a number of years, yes the decision was taken by the Competition Commission in 2004, but the reason why this is a problem is because it opens the market up to abuse in some ways, in the sense that some practitioners could really charge what they [wanted], because of other weaknesses in the legislation regarding a particular prescribed minimum benefit.

So, those are just some of the issues that were quite big as far as the practitioner is concerned as a service provider. I'm not touching on the funder side, as you haven't asked for that.

NOMPU SIZIBA: Indeed, not just yet. Let me go to Dr Broomberg.
DR NTUTHUKO BHENGU: Hi, Dr Broomberg.
NOMPU SIZIBA: Hi, Dr Broomberg. Thank you, and welcome on the show. The inquiry found that practices like over-utilisation by medical practitioners in hospitals has led to a perceived justification in the likes of Discovery being able to up membership fees annually, and that you have overly profited from the current system. What's your response to this?
DR JONATHAN BROOMBERG: That's based on quite a deep misunderstanding, and the Healthcare Market Inquiry didn't say that, by the way. It's a misunderstanding of how medical schemes work. Medical schemes are not for profit. They are owned by their members, by law, and the premiums that are paid into it are set just to cover the claims that are coming in. So nobody profits; in fact, everybody loses when there is too much use of services and inflation is high and contributions go up. So, it's a misunderstanding to say that Discovery is profiting from that. That's not at all the case.
NOMPU SIZIBA: Dr Bhengu, could you just clarify around the findings of the medical-funding aspect – some of the concerns that you raised in the report?
DR NTUTHUKO BHENGU: Yes. We did also on the concentration side – remember concentration basically means there is not as much competition as there could be. There are a few very big players. And on the administration side, certainly Discovery is the biggest on the administration side with 40% market share.

The three – Discovery, Medscheme and Metropolitan also control about 80% of medical scheme lives under management. And on the medical scheme side, again, you do find, if we take it on open and restricted schemes, such persons also come to. The medical schemes have been shrinking in number. We are down to 87. I think there were 180-something about 10 years ago. But the bottom line is that there are a few very big players in all of these big categories.

We also found that medical schemes don't do enough to hold the administrators accountable. We have a problem that, from a governance perspective, among other things, their remuneration packaging, are guaranteed and have no links to the performance of medical schemes, which we think is a weakness.

But also one of the main points we made, which you probably would relate to as well, as a consumer, is that medical schemes' design is so complex that it's hard to compare schemes like for like. And if you think there are 80-something medical schemes and at least each one or three or four options, it's an area that is very difficult to navigate.

NOMPU SIZIBA: Yes, you've suggested it's sort of opaque, and it doesn't give the consumer a sense of what it is exactly that they are buying.

Dr Broomberg, I just want to come to the issue of the over-utilisation at hospitals that was raised by the private healthcare inquiry. How easy or difficult is it for you guys to be able to police the "genuinity" – if there is such a word – of claims where perhaps there is this over-utilisation, where doctors are basically providing more tests than a patient needs, and all of that? Can you really police that at all?

DR JONATHAN BROOMBERG: To an extent we can, and we've worked very hard on that, and I think we control and prevent quite a lot of over-utilisation, and it would be much worse in the absence of that. But, having said that, a lot of it is very difficult. Remember that we are sitting in buildings far away from the coalface, the hospital. The decisions are in the hands of the doctor. I think, to be fair to doctors, quite often there is pressure on them from members, who come and say, "I've used all my savings account, doctor, please admit me so that I can have my tests paid for out of the hospital claim, rather than from my own pocket". So, we need to be careful about pointing fingers here. But, just to answer you, I think we can control it to an extent but not completely.

NOMPU SIZIBA: Dr Broomberg, just coming back to what Dr Bhengu was talking about, the inquiry is critical of medical aids offering a number of incomparable medical-aid benefits, saying that this is likely to confuse or perhaps disempower the consumer. Do you think that Discovery is guilty of this? Could you do better in this regard?

DR JONATHAN BROOMBERG: Well, I think we agree fully with the observation that you have a large number of products; they are complex and they are hard to compare. So, I can't argue with that.

But we do disagree with one of the findings of the HMI panel, which is that this is done deliberately. I cannot disagree more strongly. There are very complex regulations and rules in the laws governing medical schemes. I won't go into the detail. But the combination of those rules and the different payment arrangements with health professionals means that every

medical scheme has no choice, if it's going to comply with the law, but to have quite complex products.

Another big reason is that, if you look at the Discovery Health medical scheme, this is serving 2.8 million people right across the income spectrum, from people who can afford only a very low-cost product to people who can afford all the bells and whistles. It's a combination of those things that leads to complexity. If it was one scheme doing it and everyone else was simple, or if it was few schemes and everyone else had simpler products, but you can see right across the 82 medical schemes the products are all complex.

So we welcome the proposal from the market inquiry for quite a radical way to simplify all those products, but it will require major changes in legislation. And if those are made, then I think we can expect a simpler set of options for consumers.

NOMPU SIZIBA: What sort of tweaks in the legislation would be needed?
DR JONATHAN BROOMBERG: Well, one of the biggest is – Dr Bhengu mentioned this concept of "prescribed minimum benefits". This is the law which requires any medical scheme to offer a minimum set of healthcare services. Those definitions are highly complex. They also require that professionals and other providers are paid in full. If you could change the definitions there, and simplify them, and also change the rules around how doctors and other professionals are paid, changes to those I think could create a massive simplification.
NOMPU SIZIBA: Dr Bhengu, what are some of the key recommendations that you made in relation to practitioners, health facilities and medical aid funds? And, based on those recommendations, how are they going to fit into the future NHI, which is set to officially kick off in 2026?
DR NTUTHUKO BHENGU: Just a step back. We acknowledge that the funding side is regulated, even though we say the regulations aren't comprehensive enough. There are gaps that we try to close. But, on the other hand, on the supply side we believe there is little or no regulations beyond just the practitioner giving a certificate that you qualify – now go and practise. From the hospital side, where they've inspected your building, it meets our standards go and admit patients. Beyond that, there is very little in terms of regulation. And the problem with that is that, like everybody else, we respond to incentives and then we know everybody follows the money. So, that is one of the weaknesses that we are trying to close. One of the big recommendations is that we establish a supply-side regulator that will deal with planning in terms of establishing new hospitals. It must be made, and it must be managed properly. It's about pricing, bringing back the price stability or really just, to a degree, transparency, but so that there are at least indicative prices that can be charged by practitioners.

So, those are the two main ones. And we are saying those are actually essential for the NHI. The reason why this is important to say is that we believe that maybe some of our authorities are thinking that we do not need to come up with new regulators or big changes to the law given that the NHI is around the corner. But we say we know the NHI is going to be purchasing from the private sector as well, and it wouldn't make sense for the NHI, for authorities to do nothing and the NHI goes, and when it starts it comes to buy from this very inefficient system with practitioners and hospitals that actually aren't disciplined.

So, there is no doubt in our mind that, for it to succeed, it must come into a stable environment where suppliers and service are regulated. Private is one, but quality issues are about making sure that distribution matches need, and we do not have an oversupply of hospitals because we've shown that that has very tangible financial implications.

NOMPU SIZIBA: Dr Broomberg, I'm going to finish with you. Look, there's a confluence of things happening right now in the health sector in terms of the conversations that are being had, the findings out of the market inquiry, and us heading down the road to NHI. On this particular platform we have market analysts who look at healthcare stocks and so on, and they believe that, as we head up to NHI, the healthcare stocks have been affected. But I know that Discovery has been on record to speak positively about the NHI. With all this confluence of things happening, what are your feelings about the future? Do you feel that Discovery Health can continue to thrive going forward, or are there some genuine fears?
DR JONATHAN BROOMBERG: I have no doubt that we can continue to survive going forward, none at all. We have been and remain supportive of the NHI, but with a very clear accompanying statement, which is that we are very concerned about the types of proposals that wish to get rid of medical schemes and undermine the future of schemes. We see no reason why medical schemes can't operate fully alongside the NHI, and that's certainly a strong view that we hold and that we've communicated widely.

Having said that, I think the recommendations that you've been chatting about with Dr Bhengu and me this evening – if they are implemented, could make a very positive impact on how private healthcare operates, and that in turn could benefit the NHI as well. So, we are optimistic about the future and we see no reason why Discovery and other stakeholders in the private healthcare system can't flourish alongside a significantly improved public health system.

NOMPU SIZIBA: On that note I'm going to leave it there, gentlemen. Thank you very much for your time.