HMI findings and recommendations – FASKEN October 2019

After nearly six years of ongoing investigation, the Competition Commission ('Commission') yesterday published its long-awaited findings and recommendations in the Health Market Inquiry ('Inquiry').

At the time the Commission initiated the Inquiry in 2013, the Commission noted that private healthcare was "*at levels which only a minority of South Africans [could] afford*".

The Commission's efforts were therefore aimed at unlocking competition in the private healthcare sector which would lead to better quality products and services at lower prices which, in turn, would result in more South Africans being able to access quality health care at an affordable price.

The Commission's Health Market Inquiry Report ('Report') comes at an interesting time in South Africa. The Commission noted in its Report that, "*[w]e are concluding our work at a time when South Africa is embarking on a journey to establish a National Health Insurance Fund (NHI), a means to achieve universal health coverage. Based on the latest version of the NHI Bill, it is envisioned that the NHI will create a unified health system by improving equity in financing; reduce fragmentation in funding pools; and by making healthcare delivery more affordable and accessible, eliminate out-of-pocket payments when individuals need to access healthcare services; and ensure that all South Africans have access to comprehensive quality healthcare services*". A guide to the essential features of the NHI Bill can be found here.

There are many points that may be taken from the Commission's Report in respect of the NHI Bill, and there are many parallels, distinctions and comparisons that may be made between the NHI Bill (and its proposed implementation) and the Commission's Report. Perhaps the most immediate being the Commission's findings regarding inadequate stewardship of the private sector by Government, and perhaps (and in contrast) the Commission's findings requiring further Government regulation and involvement in the sector – a few of these recommendations which, we note, have previously been attempted in the industry and have, unfortunately, failed for one reason or another.

The adoption of the NHI Bill, as it is currently drafted, is likely to render a substantial portion of the Commission's Inquiry obsolete. Importantly, as the Commission has pointed out, the provisions of the NHI Bill will only be implemented in or around 2026 – almost seven years from publication of the Report. The Commission's recommendations therefore seem to be aimed at creating a more competitive environment in which the NHI may be introduced into and function. However, it could be questioned whether there is going to be any political reason to implement the Commission's recommendations (which will require time and money), when Government has clearly opted to pursue a different avenue to achieve access to quality healthcare for all South Africans.

We have summarized the Commission's findings and highlighted some of the Commission's key recommendations below.

Findings

In its Report, the Commission segmented the private healthcare market into three, interrelated markets:

1. The ‘facilities’ market – This includes all private hospitals, healthcare centers and clinics.
2. The ‘practitioners’ market – This includes all private practitioners, including general practitioners, specialists, nurses and pharmacists.
3. The ‘funders’ market – This includes all medical schemes, medical scheme administrators and brokers.

In respect of the facilities market, the Commission found, amongst other things, that:

- At both national and local levels, the market is highly concentrated and is dominated by three main players.
- The three main players, both individually and collectively, are able to secure steady and significant profits year on year. The three main players make it difficult for new entrants to grow and to compete on merit.
- The facilities market operates without any scrutiny of the quality of their services and the clinical outcomes that they deliver because there are no standardised publicly shared measures of quality and healthcare outcomes to compare one against the other. It is impossible for patients, funders or practitioners to exercise choice based on value (quality and price).

In respect of the practitioners market, the Commission found, amongst other things, that:

- There is no reliable up-to-date data base documenting practitioners. The private healthcare market is characterised mainly by stand-alone single practices or, in some disciplines, single-speciality group-practices. However, multidisciplinary teams are not a feature of the market. The absence of multidisciplinary teams means that specialists are performing functions that other practitioners may do without any loss of quality (at less cost).
- Current regulation of practitioners through the Health Professionals Council (‘HPC’), in particular on fee-sharing, multidisciplinary group practices, and employment of doctors, has significantly inhibited the evolution of innovative and integrated models of care.
- There is no standardised method to measure and to report on quality and health outcomes in the practitioner market. The public is uninformed and cannot compare practitioners. Practitioners too cannot benchmark their own practice nor judge on objective criteria to whom to refer.
- Practitioners are often members of professional associations which perform a number of functions to ensure professional development and business support. These associations have been seen to provide quasi-collusive forums where advice on charging, coding and participation in networks are shared leading to co-ordinated behaviour on the part of individual practitioners.

In respect of the funders market, the Commission found, amongst other things, that:

- Funders compete in an environment which is characterised by an incomplete regulatory framework, which distorts the parameters of competition.
- The principles of open enrolment (i.e. schemes should accept all applicants) and community rating (i.e. schemes should charge a contribution price for a particular plan which is identical for all members) were meant to be implemented alongside a

risk-adjustment mechanism ('RAM') (i.e schemes with above average risk-profiles are balanced through funds received from schemes with below average risk-profiles) and mandatory membership. With the absence of RAM and having to pay prescribed minimum benefits ('PMB') at cost, schemes' costs and, therefore, member premiums, are designed for the young and healthy, which has resulted in schemes competing on the risk-profile of their members. This competition on benefit design is at the expense of competition on metrics which improve consumer welfare, such as procurement of value-for-money healthcare services, increasing benefits, adopting innovations, improving service quality, and/or directly competing on premiums.

- On the supply-side, PMB, while having had a positive impact in ensuring a minimum level of coverage for members, has had unintended effects on competition. Particularly, the focus of the PMB provisions on 'catastrophic cover', to the exclusion of primary healthcare, has promoted hospi-centric care. In the face of rising costs and declining membership growth, funders have attempted to offer the lowest-cost, lowest-benefit plans possible. As schemes are mandated to cover the catastrophic conditions, funders have created bare-minimum hospital-plans. Instead of saving money, this approach has had the unintended consequence of raising costs as members are hospitalised unnecessarily in order to have treatment paid for.

In the Commission's overall findings, it states that –

> *We have concluded that the private healthcare market is subject to distortions which adversely affect competition. We find that the facilities market is highly concentrated, and there is a lack of vigorous competition or innovation amongst the largest facility groups. Competition in the funder market, to the extent that it exists, takes place on metrics which do not place the endconsumer at the forefront. The practitioner market, which is hampered by obsolete HPCSA regulations, is characterised by both unilateral and coordinated conduct which does not necessarily benefit the patient.*
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> *Overall the private healthcare market is characterised by high, and increasing, expenditure, and by excessive utilisation of health resources without any discernible or credible corresponding measure of improved health outcomes.*

Recommendations

The Commission has listed a set of "interrelated recommendations designed to promote systemic change to improve the context within which facilities, funders, and practitioners operate, enabling a shift towards a pro-competitive environment". The Commission has noted that the recommendations should be seen as a package. These include:

- The Commission should review their approach to creeping mergers to address high levels of concentration through effective merger review. The Commission should also provide guidance to practitioner associations about what constitutes pro and anti-competitive conduct.
- For effective and efficient regulatory oversight of the supply-side of the healthcare market, the Commission has recommended the establishment of a dedicated healthcare regulatory authority, referred to (at least in its Report) as the Supply Side Regulator for Healthcare ('SSRH'). The role of the SSRH will include regulation of suppliers of healthcare services, which includes health facilities and practitioners. The SSRH will have four main functions: (1) healthcare facility planning, (2) economic value assessments, (3) health services monitoring, and (4) health services pricing.

- The Commission has recommended the creation of an Outcomes Monitoring and Reporting Organisation ('OMRO') as a platform for practitioners, patients and other stakeholders to generate information on outcomes of healthcare. The OMRO will be an independent, private organisation in which key actors, such as providers (doctors and hospitals) and patients, co-operate to generate relevant and standardised outcome information.
- Changes to the HPCSA ethical rules are required to promote innovation in models of care to allow for multidisciplinary group practices and alternative care models. The Commission has also recommended that the HPCSA includes in its curriculum, for all practitioners, training to ensure that practitioners are aware of the cost implications of their decisions.
- Guidelines for associations have been proposed to ensure that the associations and their members are not at risk of potentially anti-competitive behaviour.
- To increase comparability between schemes and to increase competition in the funders market, the Commission has recommended the introduction of a single standardised base benefit option, which should be offered by all schemes. Further, the Commission has recommended the introduction of a risk-adjustment mechanism linked to the single, comprehensive, standardised base benefit option to remove any incentive by schemes to compete on risk.