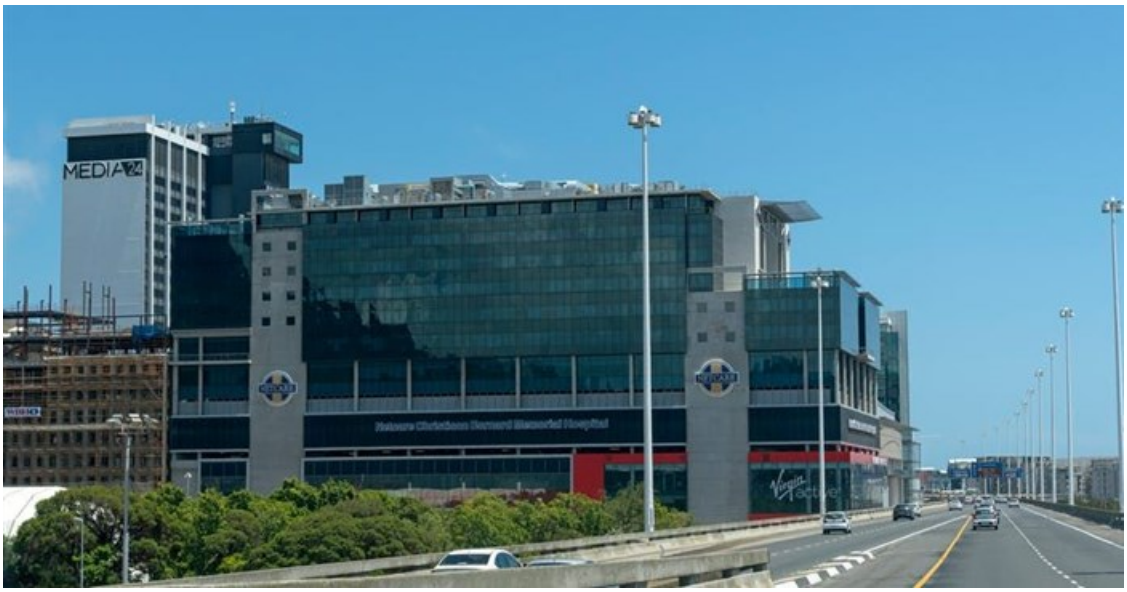
How a lack of competition in South Africa's private health sector hurts consumers

An extensive inquiry into South Africa's health market was recently concluded - the first ever process in the country that involved gathering evidence and then studying the private healthcare market from the perspective of competition and competition law.



Netcare is one of three hospital groups found to dominated the facilities market. Shutterstock

The investigation ran over five years and included over 43 million individual patient records, 11 million admissions, specifically commissioned studies, written submissions, public hearings and seminars. The investigation focused on hospitals, doctors, and funders. Funders include the medical schemes who purchase healthcare on behalf of members, and the administrators and managed care organisations that medical schemes contract with.

South Africa's Competition Commission set up the inquiry in response to prices in the private healthcare sector which, it said, only a minority of South Africans could afford. The country has a two-tiered health system. About 71% of the population uses public sector, while the private sector serves around 27%.

Ideally competition should translate into lower costs and prices, better quality, and generally more value for money for consumers. In its final report, which was released recently, the inquiry found that competition wasn't working as it should in private healthcare. The sector was characterised by high and rising costs, significant overuse, and no discernible improvements in health outcome.

Lack of competition

There were a number of factors that – alone or in combination – led to a lack of competition in the sector.

One factor is that three hospital groups dominated the facilities market: Netcare, Mediclinic and Life. They accounted for more than 80% of the hospital beds and 90% of all the admissions. These three hospital groups, both individually and collectively, were able to secure steady and significant profits year-on-year. A few firms owning the majority of the market is an indication that competition may not be working effectively.

Hospitals don't attract patients, they compete for doctors who admit patients. Most doctors had contracts with the big three. Successful entry by new hospital owners is very difficult as they cannot attract doctors as easily.

Hospital groups are also able to build additional hospitals where they aren't needed, resulting in an oversupply of beds and ultimately overuse of services.

In South Africa more people are admitted to ICU compared to eight other countries with comparable published data. The inquiry panel estimated that the country could save more than R2.7 billion – or 2% of its current private health care spend – if it halved the number of people admitted to ICUs and improved the care for patients in wards. Only the critically ill should be admitted to ICU. But the inquiry found that some of the patients who were in ICU could have been treated in wards.

There are no measures of quality of care in the public domain. This means that members of medical schemes and funders (who purchase healthcare on behalf of medical scheme members) weren't able to judge if the care provided by doctors and specialists was effective.

The entire premise of effective competition is that purchasing healthcare services should be based on value – a combination of price and quality. This isn't possible in South Africa.

There's no way to assess if the care provided was improving health outcome. This is particularly problematic as the inquiry found significant over-servicing by doctors which cannot be explained by their patients' level of illness. Doctors use a fee-for-service billing model. This means they bill patients for each service they perform during a consultation. In this system, the more you do the more you earn. This is called a perverse incentive and without knowing the impact of health outcomes neither doctors nor patients know if the extra tests or interventions are worth the cost. They also don't know if it is improving health outcomes.

The inquiry also found doctors and specialists worked as individuals -– not as a team. There is growing evidence and acceptance internationally that team-based care is better and more cost effective.

Medical schemes compete for younger and healthier individuals. To do this, schemes have created numerous benefit packages. But these packages aren't comparable. Medical schemes have done this in response to the absence of a mechanism for equalising risk between medical schemes. Medical scheme members do not know what they are paying for. Neither are they able to judge the quality of care.

Recommendations

The recommendations are aimed at creating greater competition, transparency, and accountability on how medical scheme member's money is spent. They also aim to increase competition on the supply side (hospitals, doctors, and specialists) and on the demand side where funders represent the consumer.

Recommendations include a supply side regulator, whose job will be to:

- assist provinces in issuing licenses for hospitals;

- assist with a process and a platform for price setting for doctors;
- conduct or contract out research looking at cost-effective healthcare interventions, including technology; and
- facilitate access to reliable information on quality of health and health outcomes measurement.

To increase competition on the funder's side, and to improve transparency for the consumer, the recommendations include that all medical schemes offer one comparable insurance package. In addition, government should introduce a mechanism to equalise risk between medical schemes so that they compete on the merits – not on risk or age selection.

What next

The recommendations have implications for the South African governments plan to introduce a National Health Insurance in a bid to level out the playing field between the public and private health care sectors. The plan is that the National Health Insurance will operate as a funding mechanism to move South Africa closer to universal health coverage.

Implementing the recommendations set out in the inquiry report is an essential step towards creating an environment where the purchaser – the National Health Insurance fund – will purchase from a private healthcare market that is competitive with lower costs and prices, and more value for money for consumers.

The National Health Insurance bill talks about strategic purchasing or value based purchasing which refers to using the capacity in the private sector to relieve the public sector. This aligns with the health market inquiry recommendations.

But it needs an independent supply side regulator to enable competitive price setting and coding mechanisms. Codes form the basis on which prices are determined – which is necessary for the National Health Insurance fund to reimburse providers. Value based purchasing also requires implementation of performance and outcomes reporting and monitoring.

ABOUT THE AUTHOR

Lungiswa Nkonki, is a senior lecturer, Department of Global Health,Stellenbosch University and a panel member of the Health Market Inquiry.