Administered Prices

HEALTH

A report for National Treasury

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Preface

This report was prepared for National Treasury to support its assessment of administered prices in South Africa. The objective of the study was to assess the processes involved in setting prices in regulated industries. By evaluating the efficiency, effectiveness and analytical rigour of the regulatory processes involved in setting prices for the services involved, an assessment can be made of the likelihood that the resultant tariffs approach efficient levels. Volume I of the report sets out the main findings and recommendations with supporting information relating to the individual sectors included within the scope of the study provided in a summarised form. Volume II contains more detailed sectoral reports, covering individual review of the water, electricity, telecommunications, transport, health and education sectors.

The report does not offer a detailed quantitative assessment of the performance of the regulatory regime, and is largely based on in-depth interviews and documentary analysis. The authors would like to thank the interviewees for their cooperation and valuable insights. Although much care was taken to provide a correct reflection of the opinions expressed, the authors remain entirely responsible for any inaccuracies.

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EXECUTIVE SUMMARY

This report evaluates the healthcare sector in South Africa, and focuses on an evaluation of price-setting processes and factors effecting health sector costs, as well as the identification of those areas leading to inefficient price-setting outcomes within the health sector.

The assessment covers both the demand and supply sides of the health sector, and includes the influence of the public sector.

The private healthcare market in South Africa has experienced systemic cost increases over the entire recorded history of the market. Certain services – hospitals, medicines and specialists – have however increased in cost more than others. However, in recent years medical schemes have faced dramatically increased intermediary and non-health costs in excess of the increases in medical costs.

There are key areas affecting price determination on the demand side of the health market: Employers tend to abdicate their influence on medical schemes and consequently become price takers in the market. They are excessively influenced by brokers who operate in the interests of third-party administrators. Similarly, individual purchasers of medical scheme cover have no market power, and are excessively influenced by brokers.

Government needs to consider positive inducements to achieve greater employer and employee participation in the decisions made by their medical schemes. The reconfiguration of the tax subsidy framework could be considered in this regard.

On the supply side, in the author's opinion an effective cartel exists in terms of hospitals, which prevents shifts away from fee-for-service billing to selective contracting. Pharmaceutical costs passing though hospitals are a major cost driver regardless of the ex-manufacturer price. Hospitals obtain substantial discounts from manufacturers, which are not passed on to patients.

General practitioners have been shifted into the out-of-pocket market and government legislation has limited their ability to dispense. Primary care is beginning to respond more rapidly to the emerging low-cost market. For these reasons, primary care services are not likely to remain a major driver of cost into the future.

Specialists have an incentive to collude with hospitals to protect the fee-for-service market. So they remain a significant driver of healthcare decisions within hospitals and are key to the direction costs take in the future.

Moreover, the pharmaceutical market is rife with kick-backs directed at the key agents making healthcare decisions – the doctor and specialist. Although new legislation has been introduced to weaken this link, give the pervasive nature of the practice, it may nevertheless continue.

Lastly, new technology enters the market without proper assessment of cost-effectiveness. Given the nature of the market, with demand almost guaranteed, new technology enters the market at a high price and utilisation is induced by doctors and specialists given specific financial incentives to do so.

Government should consider supply side interventions to limit the unnecessary expansion in a range of services. These include hospitals and new technology. Such interventions typically require the establishment of review committees that approve new services. Such committees already exist at a provincial level for private hospital beds. However, no such arrangement exists for expensive equipment and other areas of new technology.

The conduct of health professionals should also be regulated more assertively, with a more adequate resourcing of the Health Professionals Council considered.

In addition, the policy of permitting public hospitals to compete with private ones must be expanded, although consideration should also be given to the expansion of this initiative into a broader range of services, including out-of-hospital services such as chronic medication and treatment.

The inelastic demand for medical scheme cover opens members to the possibility of abuse by any party profiting from increased medical scheme contributions. In such circumstances regulatory intervention is needed to prevent the unfair pricing of medical scheme contributions.

Restricted medical schemes have strong governance, but lack the buying power to influence medical service providers. They are unable to access selective contracting arrangements except through intermediaries.

Open schemes, on the other hand, tend to have weak governance but in a number of cases have the buying power to monopsony price. However, the weak governance structure results in excessive profit extraction from the scheme, negating any positive influence on bringing down medical costs. Open scheme administrators are also able to exert influence on the schemes to such an extent that the interests of members are given a low priority.

The existing process for centrally bargained medical scheme tariffs is flawed, inflationary, and open to special interest manipulation. It exists within a regulatory vacuum, resulting in both medical scheme and service providers engaging in a confusing set of interactions which rarely benefit the public.

Although extensive regulation is in place to guarantee the independence of scheme management structures from both administrators and brokers, this is an area where continuous improvement will enhance the functioning of the market.

INTRODUCTION

This report forms part of a broader review of regulatory price structures and the influences on these. The main focus is on price formation processes rather than the absolute prices or marginal costs. The assessment includes a qualitative assessment of the price formation process' ability to lead to efficient pricing in a number of selected sectors, including electricity, telecoms, water, transport, education and healthcare.

This report contains an evaluation of the healthcare sector in South Africa (SA), and focuses on:

- An evaluation of price-setting processes and factors effecting health sector costs.
- The identification of those areas leading to inefficient price-setting outcomes within the health sector.

This assessment covers both the demand and supply sides of the health sector, and includes the influence of the public sector.

1. GENERALISABLE FEATURES OF THE HEALTH SECTOR

1.1 Overview

To provide some guidance on international trends in healthcare finance and provision it is important to note that a high degree of consensus exists on understanding the core problems. Although measures to deal with these problems vary across countries, it is clear that government intervention is crucial to achieving key social objectives. It is also important with respect to basic consumer protection.

Internationally, governments intervene heavily in the financing and provision of healthcare. The reasons for this are well established. Because of asymmetric information between buyers (patients) and sellers (doctors, hospitals, etc.), buyers are vulnerable to over-servicing, quackery and over-charging. Monopoly power on the part of service providers results in higher prices, lower output and lower product quality. Information is costly to consumers when services are purchased infrequently, and because of the technical nature of much of medical care, the emotional state of patients, and the urgency required at point of service.

The lack of information over the form, amount and cost of future healthcare requirements leads to a derived demand for good health – the demand for insurance. This leads to further problems affecting healthcare costs, services and quality of care.

The original theory of market failure in health, developed by Arrow (1963), explained the effect of insurance on incentives. Where the incidence of illness and the cost of treatment are uncertain and a risk-averse population is a given, health insurance is demanded. However, insured people – once they exceed any deductible – face zero costs for further healthcare purchases. Consequently insured people will buy more care than would be the case if they were paying out-of-pocket.

In addition, doctors acting as agents for their patients recommend and provide more care when reimbursed on a fee-for-service basis. They are given significant incentives to provide more services than necessary due to the financial reward involved. The net result is increased demand for existing services and new technology without any effective discretion provided by consumers. This results in systemic cost increases over time.

Incentives throughout the market are consequently so skewed that the normal rules of competition do not work. Prices remain high even when volumes traded are high. Technology remains expensive even when widely used. Hospitals and doctors remain in business even when they charge excessive prices for equal quality or fail to provide high-quality services. Incentives exist only for innovations that raise costs or increase quality regardless of cost. (Teisberg *et al*, 1994).

Current estimates indicate that the US bed occupancy is around 50%. (This is similar to the position of private hospitals in SA, based on personal communication with members of the hospital industry). This suggests substantial excessive capacity, which is sustained by the reimbursement system. Competition between health plans has had very little impact on provider efficiency and appropriate resource allocation decisions.

1.2 The role of government in the regulation of health markets

It is a well-recognised phenomenon that private markets for healthcare suffer from inherent destabilising factors, which result in:

- Systematic cost increases;
- Adverse selection (in the case of health insurance);
- Provider-induced moral hazard (where providers and suppliers of service have a profit motive to supply more services than the patient actually needs); and
- Consumer-related moral hazard (where insured patients face zero cost at point of service they have an incentive to consume services in excess of their actual needs).

Within the healthcare market, many perverse relationships exist that are geared toward the provision of services substantially beyond their value to the individual and society. The resulting cost spiral serves to destabilise the viability of private markets for healthcare. A further disturbing trend, however, is that the excessive shift of financial resources into the private environment results in an artificial shift of staff out of the public into the private environment.

Private markets for healthcare traditionally invert normal market behaviour. Whereas in other sectors demand leads supply, within the health sector the supply of services creates demand. For this reason, many governments focus on restricting healthcare supply in addition to demand-side measures. Controls are typically placed on the creation and deployment of new services and equipment. However, any attempt to deal with cost increases within private health markets requires a combination of measures, operating on both the supply and demand side.

Demand-side interventions include the regulation of the funding side of health systems, either through tax-funded mechanisms, or through regulated private insurance markets. The latter tend to involve restrictions on annual increases in contributions or premiums rather than medical service prices.

Supply-side market interventions regulate the supply of new technology, increases in the number of beds, the registration and distribution of drugs, increases in the number of new professionals (for example, doctors, nurses and auxiliaries), price controls and ceilings, marketing practices, pricing practices, dispensing, and the irregular incentivisation of doctors, pharmacists and hospitals. Such interventions can be used both for specific situations such as an epidemic and for controlling perverse practices and the abuse of monopoly power (the ability to use unfair market power or collusion to drive up prices). Since the health market is especially prone to supply-side problems, government's regulatory power is regarded as essential, especially where large private health sectors are involved.

In conclusion, no single measure or instrument is sufficient on its own to deal with the multi-dimensional nature of a health system. The regulation of the health system involves interventions on publicly and privately provided health services on both the demand and supply side. Partial approaches are also vulnerable to circumvention.

1.3 Consumer protection

Consumers are often at a disadvantage in situations where there are significant information asymmetries that require them to rely on the advice and recommendations of third parties. Consumers cannot inspect every commodity that becomes available on the market or personally test every product for safety. Great reliance is therefore placed on government authorities and paid intermediaries to assist the ordinary consumer in making certain decisions.

However, intermediaries are influenced by financial incentives and may be given specific incentives to advise consumers to use preferred goods and services. The central concern is that consumers wrongly assume they are receiving independent, objective advice. The advice given and the resulting consumption patterns are not only market distorting, but result in individuals deviating from the preferences they would have expressed if they had full knowledge of all the options.

This in essence reflects an "agency" problem. Two key groups of agents – doctors and medical scheme brokers – strongly influence what happens in SA. Unfortunately both groups have become influenced by entrenched kick-back systems, illustrating the perverse incentives of the system.

1.4 International trade protection

The international trade environment has undergone significant changes over the last 20 years. Initially through the General Agreement on Tariffs and Trade (GATT) and later through the World Trade Organisation, attempts have been made to remove international barriers to trade.

The removal of explicit barriers such as tariffs (for import protection) and industry subsidies (for export protection) has resulted in the emergence of indirect and hidden industry supports. These have been replaced by less explicit measures, such as quality controls, subsidised research and development, and voluntary export restraints.

Pharmaceutical patents are an important form of export protection, particularly where governments intervene to protect them unfairly. In the case of drugs, industrialised countries attempt to extend patent periods for as long as possible through bilateral negotiations. Once the patent has expired, competition is permitted, prices drop and production shifts to other suppliers. Thus if countries can be pressured to accept longer patent periods (irrespective of any general trade arrangements) or forced to purchase critically needed supplies at monopoly prices, the source country benefits from a windfall both in terms of jobs and foreign exchange. Developing countries are typically vulnerable to this form of arrangement due to their weak bargaining position in bilateral negotiations with industrialised countries or industrialised country trading blocs (such as the EU).

Import protection in the case of pharmaceuticals is maintained through imposing very high registration standards for pharmaceuticals under foreign patent. The delays achieved through the registration period result in a running down of the patent period, thus protecting domestic suppliers from competition. Typically this is only an issue among manufacturing countries that use these methods to neutralise one another.

1.5 Concluding remarks

Although the precarious elements and complex nature of health markets are well known by now, each country must follow its own path in addressing such issues. Costs rather than prices are focused on as healthcare service suppliers are in a position to manipulate utilisation of services – diminishing the importance of price constraints as a cost control measure.

2. COST INCREASES EXPERIENCED IN THE SA PRIVATE HEALTH SECTOR

2.1 Introduction

The private healthcare market in SA has experienced systemic cost increases over its entire recorded history. However, certain services – hospitals, medicines and specialists – have increased in cost more than others. Also, in recent years medical schemes have faced dramatically increased intermediary and non-health costs – in excess of the increases in medical costs. These trends are discussed and explained in this section.

2.2 Cost trends

Figure 1 presents the per capita expenditure for medical schemes on health benefits (medical claims) from 1988 to 2001 in 2001 prices (using the Consumer Price Index, or CPI). In 1988, the average beneficiary on a medical scheme spent just over R1,703 annually on all medical benefits in 2001 prices. By 2001 this has increased to around R4,396 per year – a 158% real increase in costs. Over the period, the coverage of benefits has also declined consistently.

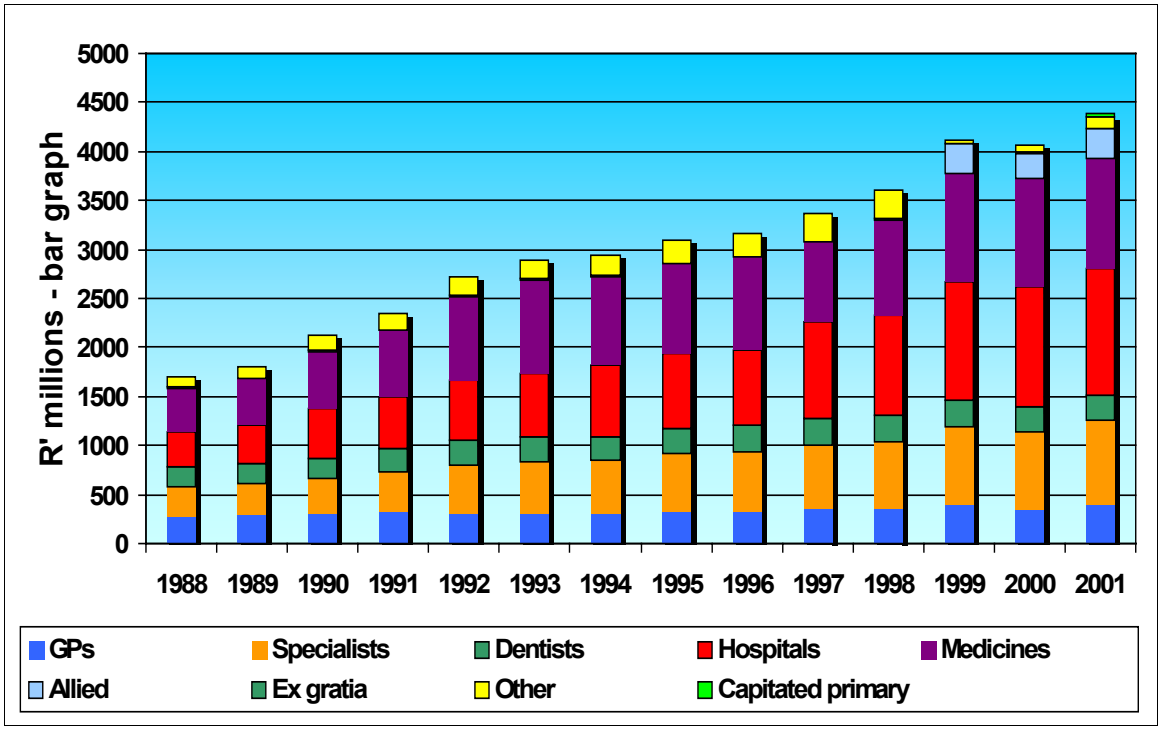
The most important cost increases are seen in hospitals (a 249% real increase), medicines/pharmaceuticals (a 153.6% real increase), and specialists (a 183.8% real increase). Although general practitioner costs appear to have been kept at a reasonable level, this is only because much expenditure has shifted to outside medical schemes.

Although there has been an increase in capitated[1] primary-care expenditure, usually seen as a cost-saving measure, it appears to have had no material impact on medical cost trends.

The share of total medical scheme expenditure attributed to hospitals, medicines and specialists has increased from 68.7% in 1991 to 74.6% in 2001. Expenditure on public hospitals has declined substantially, while the opposite trend can be seen in private hospitals. Although a part of this trend in hospital expenditure is attributable to a movement of medical scheme patients out of public hospitals, the increased expenditure in private hospitals shows a more than proportional adjustment, indicating that the increased use of private hospitals has resulted in a substantial increase in hospital costs for medical schemes.

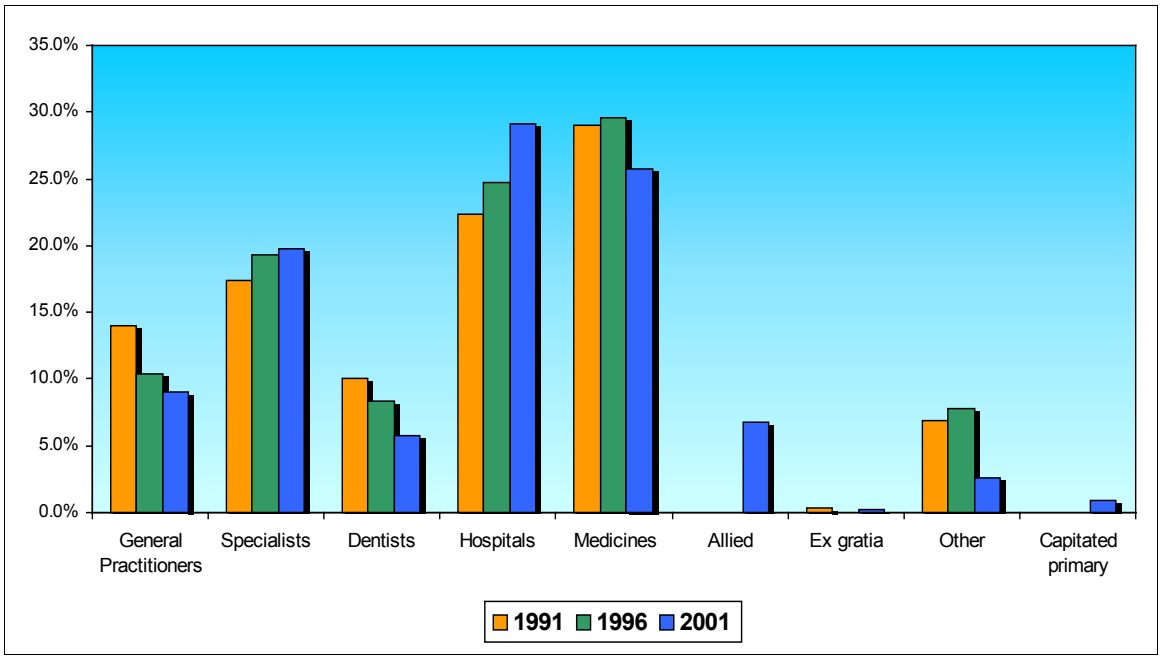
[1] Capitation occurs when a medical scheme prospectively funds a service, whether hospital-based, primary care or a combination of services, with a fixed regular payment (monthly, quarterly or annual) in respect of a defined number of potential beneficiaries. In this way a medical service provider shares in the insurance risk of the scheme, creating an incentive to contain rather than increase health costs.

Figure 1: Real per capita claims cost changes in medical schemes from 1988 to 2001 (constant 2001 prices)



[Source: Council for Medical Schemes' Annual Financial Statements of medical schemes]

Figure 2: Medical scheme cost areas as a percentage of total cost for the years 1991, 1996 and 2001



[Source: Council for Medical Schemes' Annual Financial Statements of medical schemes]

Table 1: Real per capita claims cost changes in medical schemes (constant 2001 prices)

Cost area	1991	1996	% change over period	2001	% change over period
General Practitioners	329	328	-0.6%	395	20.7%
Specialists	408	610	33.1%	870	42.6%
Dentists	234	262	10.6%	257	-2.2%
Hospitals	525	780	32.7%	1,280	64.1%
Government hospitals	*118*	*43*	*-174.2%*	*38*	*-11.3%*
Private hospitals	*407*	*737*	*44.8%*	*1,242*	*68.5%*
Medicines	681	936	27.3%	1,129	20.6%
Allied	0	0	na	299	na
Ex gratia*	7	0	na	8	na
Other	163	247	34.0%	116	-53.1%
Capitated primary	0	0	-	42	-
Total	**2,348**	**3,163**	**25.8%**	**4,396**	**39.0%**

[Source: Council for Medical Schemes' Annual Financial Statements of medical schemes]

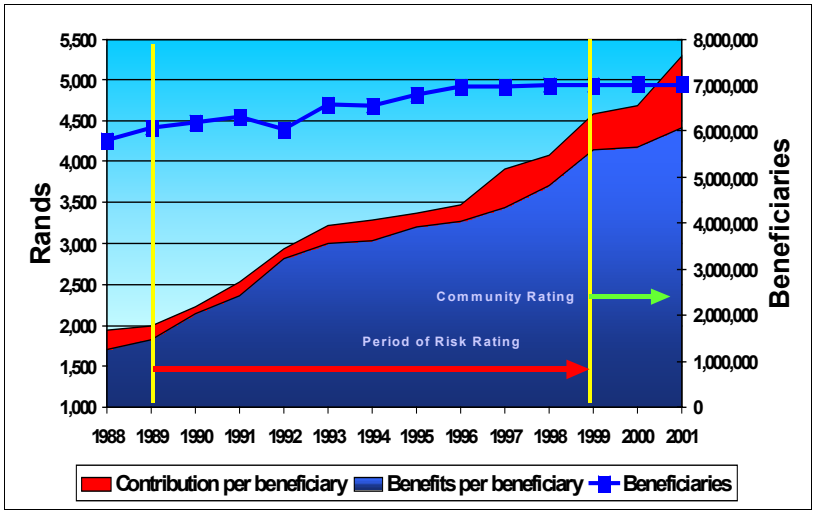
**Ex gratia* payments are benefits paid to members which are not covered by the rules of the scheme, particularly where great hardship may otherwise arise.

Figure 3 shows the real per beneficiary cost changes from 1988 to 2001 in constant 2001 prices. It also indicates particular periods when regulatory changes occurred, which could have affected cost trends. The first of these was in 1989 when scheme community rating was removed, permitting medical schemes to underwrite all people entering a scheme or to risk-rate members of a scheme. The ability to risk-rate was removed from 2000, with additional measures protecting open enrolment and minimum benefits in schemes.

The costs in figure 3 are differentiated between contributions per member (net cost over benefits costs are the red shaded area) and claims costs or benefits paid per beneficiary (blue shaded area). The red shaded area reflects the real cost changes in administration and other non-medical costs from the middle of the 1990s to 2001, which saw dramatic increases. By contrast, from 2000, benefit costs per beneficiary appear to have flattened.

The widening gap between expenditure on benefits and non-medical expenditure reflects the increasing impact of profit taking from open schemes (over-pricing administration and reinsurance), increased broker commissions (usually required to accumulate market share), and increased managed care expenditure.

Figure 3: Real costs per beneficiary, contributions and benefits: 1988 to 2001 (constant 2001 prices)



2.3 Reasons for cost increases in the private sector

The reasons for the cost increases are as follows:

- The existence of medical schemes as the third-party payors of healthcare, coupled with reimbursement on a fee-for-service basis, has caused medical costs to rise substantially due to supply-induced demand.
- The increased number of private hospital beds, coupled with market concentration in the ownership of private hospitals, has prevented the emergence of selective contracting by medical schemes for hospital services which could drive down costs. The retention of itemised billing has also resulted in deliberate over-billing by hospitals, which rely on the volume and complexity of the billing process to hide "errors".
- Medicines are marketed primarily through incentives for dispensing doctors and hospitals, which results in over-priced and increased volumes of drugs sold.
- A rise in intermediary costs can be attributed to the increase in open medical scheme beneficiaries (*see review in section 3*) where governance is weaker (resulting in higher administration fees charged than are required to run the scheme), and high broker commissions (payments to brokers are used to increase scheme market share, resulting in an increased layer of cost not found in restricted membership schemes).
- Some cost increases can be attributed to increased ageing within medical schemes. However, this trend is very slight at present, and may explain roughly 4% of the real cost increase over the years 2000 and 2001. Open medical schemes' discrimination against older and sicker demographic groups virtually eliminated this as a cost factor for the period 1989 to 1999.

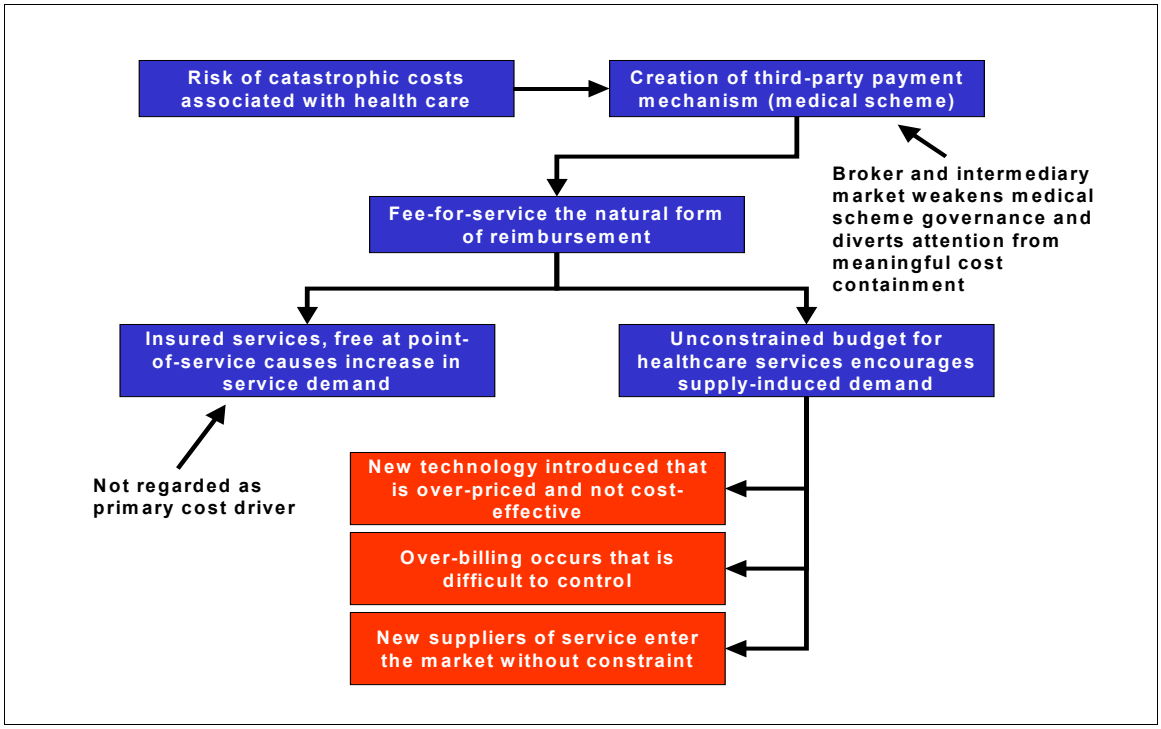
At present, government does not intervene directly to contain healthcare costs but regulates the sector for access to healthcare and to address poor governance.

2.4 Concluding remarks

Real cost increases within SA's private health market have been both persistent and dramatic over the past 20 years. An acceleration in cost occurred during the period of deregulation from 1989 to 1999 because of the increased membership of open medical schemes, which had fewer incentives to control medical costs and have substantially higher

non-medical costs. The most important areas for cost-containment in future are hospitals, medicines, specialists and non-medical expenses.

Figure 4: Overview of issues affecting the determination of healthcare costs in the private health system in SA



3. DEMAND-SIDE OF THE INDUSTRY

3.1 Overview

Healthcare is almost invariably characterised by the pooling of funds to purchase services on an individual basis. So some form of risk pooling, whether through taxation or systems of insurance, is inevitable to lower the point-of-service costs for acute-care services. However, such pooling results in a generally diminished responsiveness to certain price indicators. These tendencies are very evident in SA, as noted in section 2. Understanding these cost trends requires an overview of the operation of the market and the factors that influence costs and pricing behaviour. This section provides an outline of the key players in the private healthcare market – focusing on the demand side – which include medical schemes, scheme members (employers and individuals), third-party administrators, brokers and managed care.

3.2 Medical schemes

The purchase of private-sector medical scheme cover is income related, with only high-income groups able to access reasonable cover through a medical scheme. These are non-profit, pay-as-you-go mutual funds regulated in terms of the Medical Schemes Act and falling within the ambit of the Minister of Health. At present, most medical schemes reimburse providers on a fee-for-services basis. Members make monthly payments, with employers typically contributing at least 50%. A tax deduction is available to the employer for up to two-thirds of the full contribution. Around seven million people are covered by a medical scheme (in 2001 and 2002), with total expenditure of about R40-billion in 2001.[2]

Schemes are also divided into open and restricted membership schemes, with the latter employer based and historically community rated. (Within SA, a scheme is regarded as community rated if contributions are in no way differentiated on the basis of health status). Employer schemes cover around 50% of the total medical scheme members. Since 1 January 2000, open schemes must accept all applicants regardless of health status. Restricted membership schemes can limit applicants to employees. However, they must accept all applicants within this limitation.

Because of the initial small size of many employer-based medical schemes, in-house administration is currently outsourced to third-party administrators. The demand for these services has resulted in administrators turning into substantial organisations with expanding interests in commercial for-profit opportunities available in the market. Administrators are primarily responsible for setting up open schemes.

3.3 Medical scheme members

3.3.1 Employers

Membership of a medical scheme is to a large extent arranged via an employer, irrespective of whether or not an open or restricted membership scheme is used. Employer behaviour is thus an important factor affecting the way in which medical schemes behave. Many employers take very little interest in the quality of scheme selected and often take the advise of brokers who are not independent (*see also section 3.5*). As a consequence, employers within the open-scheme market largely give away their market power and become price takers. Here the price is the contribution paid.

[2] Council for Medical Schemes, Annual Report, 2001

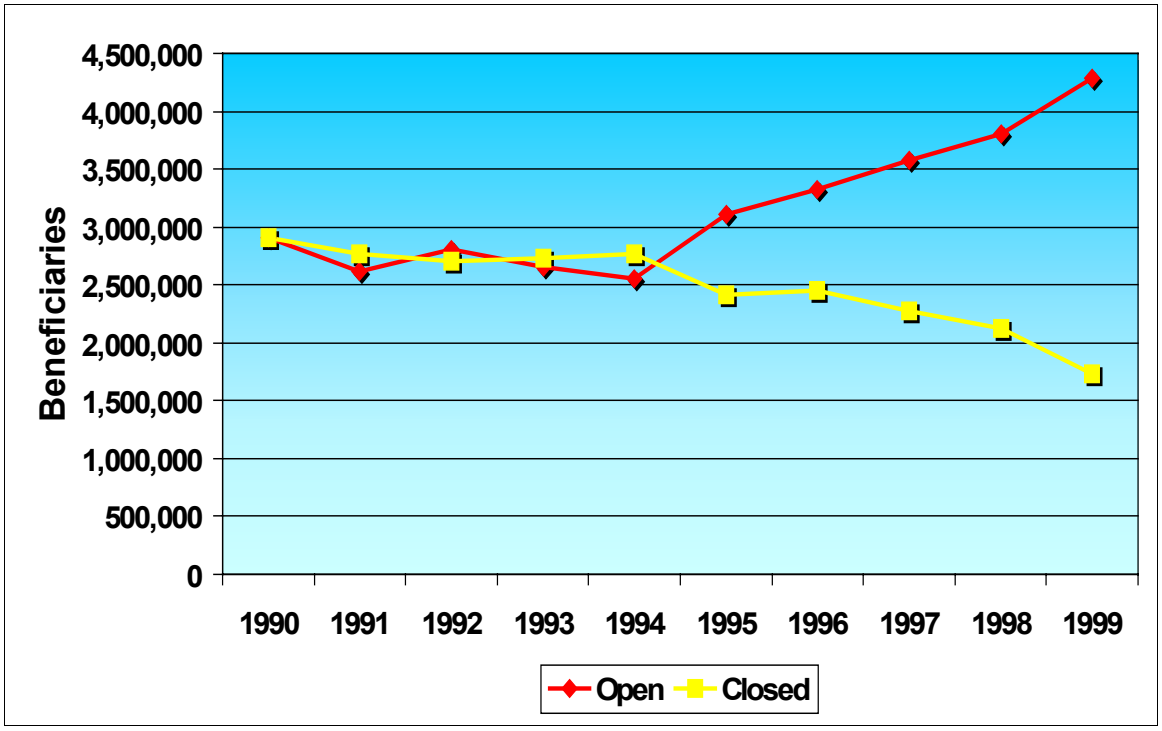
Employers have traditionally played an important role in obtaining medical scheme cover for their employees, usually those with a higher income. Employers often set up the medical scheme and subsidised the contribution, which extended to retirees and their dependants. This resulted in a large number of small “closed” medical schemes, where membership is restricted to the employees of the relevant employer. Coverage in all instances involves the employee and dependants.

During the 1990s, employee benefit advisors (brokers), incentivised by commission windfalls, started to advise employers to shift to a “total cost to company” (TCC) approach. This allowed the employer to cap employee remuneration and the employee to choose his/her employee benefits voluntarily – and introduced a major shift of membership from closed (or restricted membership) schemes to open schemes.

The net result from these shifts is the following:

- Employers provide virtually no oversight of open medical schemes as the governance structures are dominated by the administrator. Regulations have recently changed to ensure an arms length is maintained between the scheme and the administrator. However, for much of the period 1993 to 2002, administrators were permitted undue access to the decision-making of these schemes – which still continues. Members’ and employers’ weak influence on scheme governance results in large increases in *non-medical costs* – scheme funds spent on goods and services not involving medical services.
- Employers’ weaker influence on schemes has resulted in higher medical claims costs, as they no longer make any effort to ensure schemes reduce medical claims costs in the interests of their members. Open medical schemes often negotiate deals to lower medical costs outside of the medical scheme, and use the discount obtained to increase their margins on the administration of a medical scheme.
- The influence of brokers, remunerated directly or indirectly by administrators, reduces the impact of competition – the influence members shopping around for schemes should have in incentivising schemes to keep costs down. Brokers merely advise members to go to the schemes where they receive the largest commissions, so the choice of scheme is not influenced by the quality of benefits or the contributions.

Figure 5: Medical scheme beneficiary trends in open and closed (employer-based or restricted membership) schemes from 1990 to 1999



[Source: Council for Medical Schemes, medical scheme returns for the period 1990 to 1999.]

3.3.2 Individuals

An individual market for medical schemes exists for those income earners whose employers operate on a TCC basis, or who are self-employed. A very substantial number of individual medical scheme members are employees of the civil service (around 500,000 principle members and a total of about 1.5-million beneficiaries), which since around 1993 permitted medical scheme membership and choice of scheme to be voluntary. These individuals often access schemes using brokers who advise individuals rather than groups. Individual members have virtually no market power in relation to schemes or medical service providers. As a result they access a market which can increase non-medical costs (administration fees, broker fees, etc.) with virtual impunity in the absence of normal market checks and balances.

3.4 Medical scheme administrators (third-party administrators)

Medical schemes require the performance of certain basic administration functions. These include managing membership files and claims. Since the economies of scale did not exist in the large number of small medical schemes in SA to develop the required systems, the need arose to outsource these basic functions. This resulted in the emergence of third-party for-profit administrators. A single administrator would consequently contract with many medical schemes.

Over time certain administrators began to initiate the development of open medical schemes over which they had a high degree of influence, even though they could not legally own the scheme. Contracts with administrators typically involve payment of a fixed percentage of gross contribution. As a consequence, third-party administrators had very little incentive to contain medical cost inflation. The larger the medical cost increases, the larger the increases in administration fees.

Administrators have grown to such an extent as organisations that they offer a range of services which can be sold on to medical schemes over and above pure administration. These include managed care services, bill review systems and insurance products. Given the undue influence administrators can exercise over the medical schemes, many contracts entered into are harmful to the interests of the members. Increased regulation and regulatory oversight have consequently evolved to review or limit contracts with "related parties" of the administrator.

To drive membership growth within open medical schemes controlled by a given administrator, large sums of money have been paid to brokers to persuade employers to move their employees away from restricted membership schemes. These payments have not only been very costly but often also illegal, resulting in perverse price wars – with the members going to the administrator able to pay the highest commission. Members who are charged high administration fees to the scheme, or reinsurance contracts used to extract reserves away from the scheme ultimately pay these very high prices. Ongoing commissions, often referred to as co-administration, are used to retain members. Very little actual service is provided for these ongoing commissions. Payment is made primarily to prevent the broker from moving the members elsewhere.

3.5 Brokers

Two forms of broker exist, those serving the group or employer market and those targeting individuals. The group market is primarily serviced by fairly large, established broker groups which typically advise employers on a range of employee benefits. The individual market is serviced by smaller, less well-established broker groups. Probably the largest individual market is that for civil service employees seeking placement within an open scheme.

As shown above, a perverse market for broker services emerged after the deregulation of the Medical Schemes Act in 1994 (*see figure 5*). Brokers, incentivised by large illegal commissions paid by administrators, targeted employers running small in-house schemes and persuaded them to move to designated open schemes. Around 1.6-million beneficiaries moved from closed (restricted membership schemes) to open schemes between 1993 and 1999. Between 10% and 15% of gross contribution income was paid per member shifted, with ongoing commissions of around 6% to 7%. Administrators unable to pay these commissions were stripped of members.

Changes to the Medical Schemes Act in 2003 have now limited so-called co-administration payments to R50 per member per month or 3% of gross contributions, whichever is the lower. It has also restricted such payments to medical schemes, with administrators legally barred from making any form of payment for broker services. It is likely that a number of administrators will attempt to circumvent these limitations.

3.6 Managed care and selective contracting

In recent years managed care companies have emerged, often with strong ties to third-party administrators. Their role has been to provide services specialised to contain medical cost increases. These include:

- Pre-authorisation services;
- Medical case management;
- Disease management programmes (usually for chronic conditions and HIV/Aids); and
- Networked service providers and capitation arrangements (these can involve primary care, specialist services and hospital-based services, but are almost exclusively limited to primary care in South Africa).

It is difficult for managed care companies to operate except via arrangements with administrators. Administrators will try very hard to ensure that their companies get preference in any arrangements set up with medical schemes. They use their influence over the trustees to arrange this.

Certain managed care operators exist in a grey area outside the medical schemes regulatory environment, providing direct services to employers (usually for those employing low-income groups). These services are primarily for HIV/Aids.

Within this market the strong related-party relationship between the administrators and the managed care companies significantly reduces their potential effectiveness. Many administrators try to reduce medical service costs to increase the margins achieved on their own services rather than to reduce medical scheme costs.

3.7 Inelastic demand for health insurance

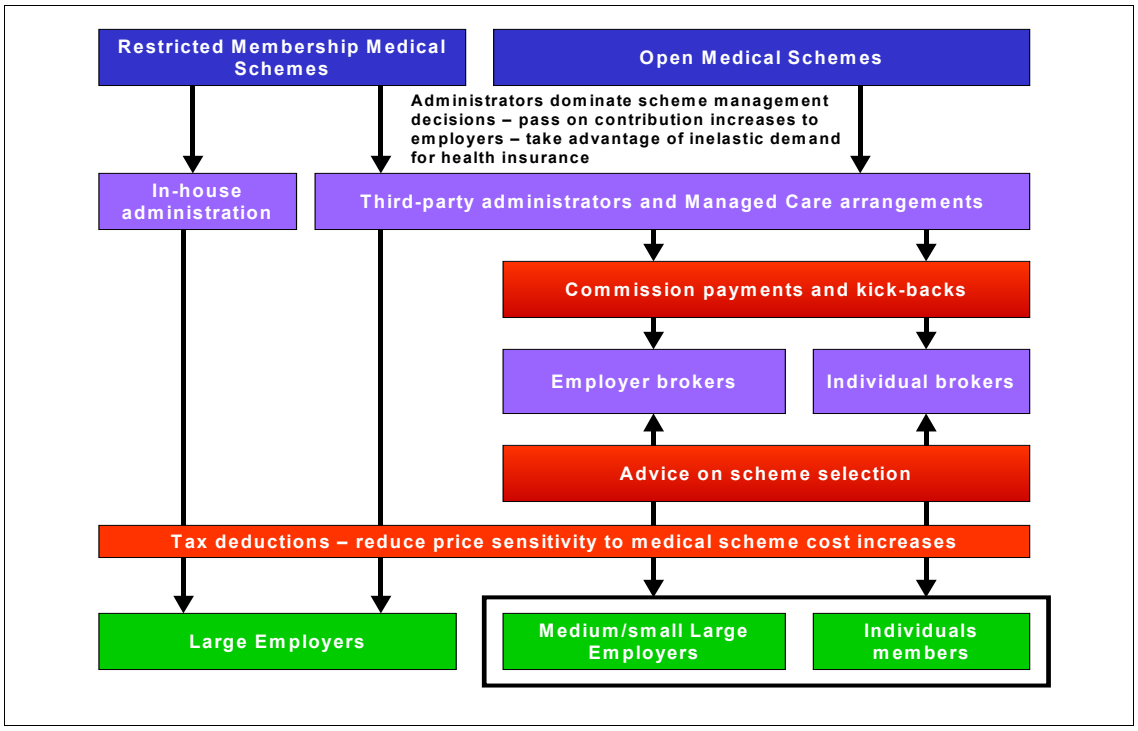
The demand for medical scheme cover, quite aside from the issue of tax and employer subsidies, is inelastic for a number of more natural reasons. The risk of catastrophic financial loss, with the additional concern that essential medical services could be denied due to the non-availability of funds, both serve to keep the demand for healthcare constant or rising, even in the face of real contribution cost increases. In addition, a rise in real healthcare cost (the costs of the services themselves) increases the risk of catastrophic financial loss or reduced access to private health services. Thus increasing health service costs effectively serve to increase the need to have health insurance. All evidence suggests that there has been an upward sloping demand curve for medical scheme cover over the past 20 years (*see figure 6*). This tendency has diminished in the past five years only because cover has become unaffordable for certain income groups.

3.8 Concluding remarks

Key areas that affect price determination on the demand side of the health market are:

- Employers are price takers when approaching open medical schemes. This reduces the incentive for medical schemes to compete on price.
- Members paying contributions are price insensitive to medical scheme contribution increases. This results from high employer subsidies encouraged by a generous government tax deduction for employer contributions to medical schemes on behalf of their employees.
- Administrators have to compete for members in open schemes by bargaining up broker commissions. This increases the cost of schemes.
- Brokers are remunerated by administrators paying the highest price for members. Consequently they do not provide accurate information to members choosing a scheme. This weakens price and benefit competition between schemes, reducing any pressure they may feel to keep medical costs down.
- Managed care services are often sold into schemes via third-party administrators. In many instances these services merely serve as an additional layer of administration fee, with questionable benefits for the scheme.

Figure 6: Key relationships on the demand side of the private health sector in SA



4. SUPPLY SIDE OF THE INDUSTRY

4.1 Overview

Weak competition on the demand side has direct implications for behaviour on the supply side of the private healthcare industry.

4.2 Hospitals

Private hospitals in SA are primarily for-profit and reimbursed on a fee-for-service basis. There are three main hospital groups that dominate the private market – Netcare, Afrox and Mediclinic. For the remainder, most hospitals are independently owned (not part of a group) or belong to very small groups. Of the not-for-profit private hospitals, most serve mines, and were originally intended as occupational health facilities. A small number of church hospitals exist, mostly treating indigent and low-income patients with subsidies from provincial health departments.

The establishment of these three large hospital groups has served to reduce the possibility of competition within the private healthcare market. It is also not clear that a mere increase in the number of hospital groups would provide a solution. Given the small size of the market and the need for a degree of interconnectedness between health services to enable them to operate efficiently, it is more appropriate to control abuse of market power.

With many more medical schemes to hospitals, however, and in the absence of a clear strategy from government to control abuse, there is little possibility that hospital behaviour can be altered significantly – despite the fact that medical schemes centralise the determination of a large, but not all-inclusive, range of hospital fees via the Board of Health Funders' (BHF) recommended schedule of tariffs (*this is discussed in more depth in section 5*).

A recent initiative by the Department of Health attempts to address an aspect of this abuse by permitting public hospitals to compete for medical scheme patients. Differentiated amenities for private patients in public hospitals have been approved and a pilot process is in place to develop contractual arrangements with medical schemes. The process would probably take about two years to evolve fully. Once mature, however, it should play an important role in benchmarking hospital costs in the private market.

4.3 Primary care providers

Primary care providers have typically involved individual or group general practitioner practices serving the public on a fee-for-service basis. As medical costs began to rise for medical schemes, primary care benefits were the first to come under pressure – with annual benefit limits, deductibles and co-payments. Doctors' consultation fees were also put under pressure by the BHF tariff, which offered only low increases.

As a defence against this move, many general practitioners shifted into medicine dispensing to supplement their incomes. Perverse practices emerged, however, as a substantial portion of the pharmaceutical manufacturing industry began to provide doctors with kick-backs in one form or another – bonuses, discounts, free holidays – to sell their medicines. In the case of discounts, general practitioners charge the published market price, but obtain the product at a substantially reduced cost.

General practitioners have also grouped themselves into independent practitioner associations (IPAs) to be able to prevent medical schemes from selectively contracting with particular doctors, and to establish joint negotiating platforms for extracting kick-backs from pharmaceutical companies. The latter typically involves the establishment of a limited drug

list which pharmaceutical manufacturers have to “buy” their way into. The limited list is ostensibly selected on the basis of cost-effectiveness criteria. This is rarely the case in practice, however.

In response to the need for low-cost healthcare, primary care networks have been established, often with salaried staff. These operations differ considerably from that of the IPAs as they involve a corporate structure and capitation contracts. In other words, medical schemes pay a fixed flat fee (capitation fee) per beneficiary, which is paid over to the network on a monthly basis. The network is thus not paid on a fee-for-service basis, and accepts a degree of risk associated with the contract. It is assumed that the network can manage this risk through carefully handling input costs and medical protocols.

The most logical model for providing cost-effective healthcare involves having the primary care service operate as a gatekeeper for hospital services. At present this gatekeeper function does not exist in the private market for healthcare, except in the case of mine hospitals. Fee-for-service arrangements encourage relationships between specialists and hospitals, with increased referrals rewarded in some manner, for example through free consulting rooms on hospital premises and shares in hospitals. The existing primary care capitation arrangements incentivise hospital or specialist referrals, as the primary care provider only shares risk in relation to the cost of its service. To minimise costs, patients are under-treated or shifted up the referral chain.

The models of care that involve extensive co-operation between primary care and hospital services have not occurred as yet because administrator-driven schemes have no incentive to optimise healthcare, while hospitals make use of their market power to prevent such arrangements – which would place their high-margin business at risk – from being established.

4.4 Pharmaceuticals

Pharmaceutical companies influence the principle decision-maker in the process of selling drugs – the doctor – both through general and specific incentives to sell. The former occurs because of the percentage mark-up, while the latter occurs when bonuses, discounts and other inducements are used to get doctors to favour particular brand-name products.

Virtually all the incentives in the private market induce doctors to prescribe high-cost drugs as often as possible. This behaviour permits the pharmaceutical industry to charge higher prices than they would in a normally functioning market.

The proposed reforms in the Medicines and Related Substances Control Act (Act 90) focus on addressing various incentives for doctors to over-prescribe or to prescribe the drugs from which they receive the greatest profit. If they work, generic substitution, transparent pricing and the outlawing of specific inducements to doctors should increase price sensitivity in the market.

There are essentially two elements driving up volume in the private market for drugs.

The first relates to a general incentive given to prescribe higher priced drugs often – the percentage mark-up. Until now the mark-up has been provided to doctors, pharmacists and hospitals as a dispensing fee, that is, to cover the cost associated with procuring, storing and dispensing a drug. The mark-up has been reflected as a percentage on a published price (e.g. the “Blue-book” price). The final purchaser – the patient – pays a price which includes this mark-up. As the medical scheme reimburses the patient or directly pays for the drug in the private sector, patients are not very price sensitive. Even if they were concerned about the price, they are not in a position to question the decision of the doctor. The general mark-

up therefore creates a strong incentive to increase the volume of drugs prescribed and to prefer the higher priced drugs.

The second element involves specific incentives targeted at doctors responsible for both prescribing and dispensing. These specific incentives are additional to the general incentive and are used to create preferences for specific companies or brand names. Incentives take the form of:

- *Kick-backs*: e.g. overseas trips, direct financial payments for of proof volumes prescribed and dispensed, etc.;
- *Bonusing*: this is essentially a direct financial kick-back in exchange for proof of volumes prescribed and dispensed – the extent of the bonus is linked to target volumes;
- *Discounts of the published price* (this substantially increases the impact of any percentage mark-up;
- *Formularies*: doctor groupings such as Independent Practitioner Associations (IPAs) create limited drug lists. Pharmaceutical companies essentially have to pay a "fee" to get on the formulary. Limited lists used by the final purchaser are usually quite beneficial for cost management. However, when developed used by the agent (i.e. the doctor) they are used to "pressurize" pharmaceutical companies for additional compensation.

When these elements are combined with a price insensitive final purchaser (i.e. the medical scheme), the market will be faced with general price and volume increases beyond what is actually needed and high prices (due to the preference created for high price drugs).

As the mechanisms causing the eventual cost increases (price x volume) result from a combination of perverse elements, market corrections are required through a combination of instruments. No single measure is sufficient on its own.

The various measures described below are part of the overall policy package introduced by the Medicines and Related Substances Control Act.

(a) The general mark-up: The appropriate response here is to move to a flat-rate dispensing fee rather than a percentage mark-up. However, without addressing the specific incentives given by pharmaceutical companies to agents, very little will be achieved by this measure on its own.

(b) Specific incentives: These are dealt with through:

i. *Outlawing of bonusing and discounting*: On its own however, these measures are not sufficient, as there are too many ways that kick-backs of one form or another can be given, both directly and indirectly.

ii. *Transparent pricing from manufacturer to final purchaser*: This measure can assist in making all market participants aware of the prices and mark-ups being paid from the manufacturer to the final purchaser. However, although this measure is useful, it will achieve little when the purchasing decisions are controlled by agents receiving kick-backs.

iii. *Mandatory generic prescribing*: This breaks the crucial link between the act of prescribing and dispensing – greatly disrupting the ability of the pharmaceutical manufacturer to incentivise a chosen agent. This is one of the central measures that begin to address the core problem of specific incentives to agents.

iv. *Single exit price*: This eliminates specific discount-related incentives being provided to agents. It therefore removes an important perverse incentive.

v. *Elimination of the dispensing doctor*: This in conjunction with mandatory generic prescribing by pharmacists breaks a number of critical collusive arrangements, making it far more difficult to co-ordinate the allocation of specific incentives as easily as before.

These measures achieve a number of rational objectives in relation to overall health policy:

(a) The general trend in the cost of drugs can be addressed, reducing the cost of medical scheme cover and preventing a drop out of membership on to state services.

(b) Basic consumer protection is enhanced through removing incentives to prescribe drugs that are not either not needed or may even be harmful to members of the public.

Despite the above policy reforms, it is unlikely that medical schemes will feel the effects of these reforms until such time as they become intelligent purchasers of healthcare.

4.5 Other suppliers of goods

Other suppliers of medical goods and services include equipment suppliers and laboratory services. Both these markets operate similarly to that for pharmaceuticals. Doctors sometimes own shares in medical equipment suppliers, while direct kickbacks are made to doctors who overuse laboratory tests. In neither case are the final prices negotiated influenced by medical schemes.

4.6 Concluding remarks

The pricing of goods and services on the supply-side of the private health market are heavily influenced by incentives provided to the key agents in the market, doctors. Once doctors have been influenced via financial rewards of one form or another, prices are pushed up, and volumes sold increased.

Government has intervened at this stage through the introduction of Act 90. This will impact on certain peripheral aspects of the perverse market for drugs. It is however not clear that a regulatory structure up to the task of achieving compliance and further development of the regulatory environment will be put in place. The regulation without a regulator will achieve little, and will potentially be circumvented with ease.

As things stand no process has been put in place to filter the importation and use of new technology that is not cost effective. Regulatory intervention is typically required in such instances, where review committees assess the need for new equipment against established criteria. This serves to limit the introduction of new technology at excessive prices, the costs of which are passed on to the third-party payor (the medical scheme).

Measures to deal with perverse behaviour amongst medical professionals are always a difficult matter. The most appropriate measures involve a combination of strong conduct oriented legislation, coupled with rapid and firm enforcement. Given the individual nature of medical treatment, direct interference with doctor discretion may not always work well. Overall cost containment is best achieved however through market-related interventions that permit the group purchasing of health care services.

5. REVIEW OF TARIFF SETTING VIA MEDICAL SCHEMES IN SOUTH AFRICA

5.1 Overview

Two key areas of fee setting affect the final price of purchase for many health goods and services. The first involves the fees paid for professional services such as doctors, surgeons, dentists, specialists, etc. The second relates to tariffs paid for hospital services. Outside of this are a not insignificant range of goods and services which are not influenced in any way by the final purchaser – pharmaceuticals, laboratory tests, gases, etc.

5.2 Medical schemes and tariff setting

Medical schemes are insurance vehicles and therefore "reimburse" members for actual costs incurred. This reimbursement need not involve payment of the full price paid or cost incurred. Medical schemes have therefore traditionally operated not as purchasers of health care but the insurers of purchasers of health care. As a consequence the "tariff" set centrally by the Representative Association of Medical Schemes (RAMS – now Board of Health Funders (BHF)) were not prices.

However, as many medical scheme members would not be able to pay health care service providers unless reimbursed by a medical scheme, the tariff set by RAMS (now BHF) has the effect of being a price. Where doctors were "contracted in" (see below) the tariff operated unambiguously as a price, as the reimbursement rate matched the final amount paid. However, doctors contracted in on out on a voluntary basis, reflecting the true nature of the tariff as reimbursement.

The almost continuous and seemingly irresolvable conflict in price determination between service suppliers and medical schemes stems largely from the unavoidable requirement placed on the market to set fees centrally. Given the vast number of procedures, equipment and consumables, a degree of uniformity in pricing is required to ensure that medical schemes and service providers can cope with huge volumes of invoices. If a different price schedule existed for every medical scheme, service suppliers would be given a near impossible administrative task. However, to negotiate a single schedule in a manner acceptable to all parties is virtually impossible.

Until 1993 RAMS had the statutory authority to publish the official price list for all medical schemes. This status was removed from them in 1993, after which they could only publish a recommended schedule of benefits. Schemes did not have to adhere to the prices. RAMS was permitted to perform this function, in terms of competition legislation, only as long as they did not enforce the price list on schemes. Individual schemes could negotiate separate tariffs with service providers if they wished. However, this was nearly impossible to do, and consequently the RAMS schedule of fees effectively became uniform throughout the market.

In response to this hospital groups and medical professionals set their fees in accordance with their own processes. These tariffs are normally higher than the RAMS fees and medical scheme members are "balance billed" the difference. Threats to significantly increase the levels of balance billing are often used by service suppliers to extract concessions from RAMS, now BHF, to increase their schedule of fees. In return, medical schemes penalise service providers that balance bill by making the member pay the bill first before any reimbursement occurs. This practice, especially if it becomes widespread, has severe impacts on hospital cash flow.

Medical professionals are permitted to establish a scale of benefits in terms of existing competition legislation via the South African Medical Association. This is because it is a

professional association. By contrast, hospitals, are not permitted to set tariffs via the Hospital Association of South Africa (HASA), although for a number of years they were given an exemption to do so. With the passing of the new competition legislation the exemption fell away and has not been made available again. The rationale for the original exemption was in any case highly questionable. It is however not clear what rationale exists for permitting horizontal collusion in the setting of conditions of service and fees by doctors and not hospitals.

The BHF scale of benefits however excludes a large number of items, termed "non-chargeables", which are priced outside of the control of medical schemes. Although non-chargeables emerged via agreement between hospitals and RAMS/BHF they have resulted in an area of healthcare cost where the final prices are not in any way influenced or controlled. Thus when BHF squeezes the tariffs on the scale of benefits, hospitals increase the volumes and prices of non-chargeables paid for by schemes. The net result being a net overall real cost increase.

In recent years, with the aid of regulation, medical schemes have begun to contract directly for healthcare goods and services, on behalf of medical scheme members. In this relationship prices and not reimbursement rates are set by medical schemes.

During 2002 and 2003 matters have worsened to such an extent that BHF and service suppliers have approached government to provide an alternative bargaining framework. A ministerial committee has been appointed which will make its deliberations known in due course. The Competition Commission is also independently pursuing the matter.

Presently Government plays no part in price setting within the private sector. Government also does not control the contribution increases charged by medical schemes.

5.3 Some history

The following are extracts on a history of price setting between medical schemes and service suppliers from around 1969 to the present by van den Heever (2003). This review shows the complex nature of the centralised bargaining process for healthcare services. Over the years a continuous conflict over prices occurred, resulting in ongoing instability in the market.

"The setting of medical fees between medical schemes and the medical profession was always a problem and a source of conflict. The Medical Association often objected to the fees that were set and the arbitration mechanism. This resulted in many doctors choosing to opt out of the tariff of fees system. If a medical practitioner was contracted in, then the law guaranteed payment of the account. This provided an incentive for doctors to remain contracted in. In order to resolve this conflict, a Remuneration Committee was set up in terms of the Medical Schemes Amendment Act 95 of 1969, to investigate the tariff of fees at least every two years. The objective of this amendment was to improve the arbitration mechanism such that disputes would not result in further doctors choosing to opt out of the tariff of fees system, which was regarded as damaging to doctor/patient relationships." (van den Heever, in publication).

"However, the medical profession eventually regarded the Remuneration Committee in a negative light. Allegations were made that the Act was being used to control the medical profession and that the inflexible provisions relating to the Remuneration Committee were financially prejudicial to medical practitioners and dentists. By 1978 the Dental Society and the Medical Association indicated that they were no longer prepared to participate in the activities of the Remuneration Committee. Consideration had been given to regulating against the free choice of doctors to contract out. However, publication of draft legislation to this effect resulted in a further 1,600 medical practitioners deciding to contract out. By this

time 3,941 out of a total of around 14,000 medical practitioners had already contracted out." (van den Heever, in publication).

"As a consequence of these conflicts, the *Medical Schemes Amendment Act 51 of 1978*, abolished the Remuneration Committee and the Commission that made recommendations to the Council on fees. Provision was made for the Medical and Dental Council to determine fees. This was allowed on condition that it prevent further contracting out. If not successful the Minister would step in to regulate the ability of the medical profession to contract out. The *Medical Schemes Amendment Act 42 of 1980*, made provision for contracted in doctors to send accounts *directly* to medical schemes. This issue had been a constant source of conflict between medical practitioners and government. The previous dispensation only allowed accounts to be sent to patients who had to pass them on to the medical scheme. Medical practitioners argued that this caused extensive delays and reduced the benefit for contracted-in doctors of guaranteed payment. However, the Browne Commission (in 1986) recommended very strongly in its interim report that the provision allowing direct payment be scrapped and that the doctor send the first and second account to the patient and only the third directly to the medical scheme. Upon receipt of the account, the scheme was required by law to pay within six weeks." (van den Heever, in publication).

"The *Amendment Act 59 of 1984*, eliminated the principle of contracting-in and contracting-out. Any profession or service supplier was permitted to determine their tariffs through their respective statutory control bodies. The *Representative Association of Medical Schemes* (RAMS) was, however, allowed to determine a scale of fees after consultation with representatives of suppliers of services. If a service supplier were to charge fees equal to or less than the fees indicated on the scale of benefits, the medical scheme was required to pay the supplier of the service directly, provided the scheme offered that benefit." (van den Heever, in publication).

5.4 Concluding remarks

The complexity of medical scheme claims processing makes the establishment of a central bargaining mechanism for a range of prices inevitable. However, this process comes with in-built instability, as it is not possible to please everyone, particularly with medical costs rising significantly in real terms. This results in irreconcilable differences which can only be resolved through government intervention. The development of direct contracting between certain medical schemes and service providers in the future will reduce some of this complexity. However, this cannot be a market-wide solution as direct contracting only works in the case of very large schemes.

The following issues are therefore important:

- A central bargaining process is required for the setting of fee-for-service rates in the private sector.
- This bargaining process should be regulated: the following is an illustration of Governments potential interventions:
  - A formal bargaining process between service providers and medical schemes be constituted in terms of a clear legal framework;
  - All fees charged should be subjected to this negotiation (including pharmaceuticals, hospital fees, hospital gases, existing non-chargeables, etc.);
  - The tariffs set should become the single price for a health service, i.e. there should be no balance billing (i.e. service suppliers cannot have a different price from medical scheme reimbursement rates);

- Negotiated price changes should only become official, and Gazetted, with the approval of Government; and
- Non-fee-for-service charges (selective contracting) should be negotiated outside of this framework between individual medical schemes and service providers – with the proviso that the resulting charges cannot exceed the Gazetted prices.

6. SUMMARY OF FINDINGS AND RECOMMENDATIONS

The private health care market in South Africa has experienced systemic cost increases over the entire recorded history of the market. Certain services have however increased in cost more than others. These are hospitals, medicines and specialists. However, in recent years medical schemes have faced dramatically increased intermediary and non-health costs – in excess of the increases in medical costs. The influences on costs in the medical sector are discussed below, a distinction is made between demand side cost factors, supply side cost factors and medical scheme cost factors

Demand-side cost factors

Employers tend to abdicate their influence on medical schemes and consequently become price takers in the market. They are excessively influenced by brokers who operate in the interests of third-party administrators. Similarly, individual purchasers of medical scheme cover have no market power, and are excessively influenced by brokers.

Brokers targeting employer groups rely on large payments from administrators for their remuneration. As the employers do not directly pay for broker services, brokers serve the administrator interests. As a consequence, employers are not advised correctly on options in the market. Brokers are also in a position to bargain up commissions to attract membership. Likewise, brokers targeting individual members are remunerated by administrators and not the members they are placing. As a consequence their advice is not independent, and administrators are forced to bargain up commissions to attract membership.

Supply-side cost factors

On the hospital side an effective cartel exists in the author's opinion which prevents shifts away from fee-for-service billing to selective contracting. Pharmaceutical costs passing though hospitals are a major cost-driver regardless of the ex-manufacturer price. Hospitals obtain substantial discounts from manufacturers, which are not passed on to patients.

General practitioners have been shifted into the out-of-pocket market and government legislation has limited their ability to dispense. Primary care is beginning to respond more rapidly to the emerging low-cost market. For all these reasons, primary care services are not likely to remain a major driver of cost into the future.

Specialists have an incentive to collude with hospitals to protect the fee-for-service market. They remain a significant driver of healthcare decisions within hospitals and are key to the direction costs take in the future.

Moreover, the pharmaceutical market is rife with kickbacks directed at the key agents making healthcare decisions, the doctor and specialist. Although new legislation has been introduced to weaken this link, give the pervasive nature of the practice, it may continue nevertheless.

Lastly, new technology enters the market without proper assessment of cost-effectiveness. Given the nature of the market, with demand almost guaranteed, new technology enters the market at a high price and utilisation is induced by doctors and specialists given specific financial incentives to do so.

Medical schemes

Restricted schemes have strong governance, but lack the buying power to influence medical service providers. They are unable to access selective contracting arrangements except through intermediaries.

Open schemes on the other hand tend to have weak governance, but in a number of cases have the buying power to monopsony price. However, the weak governance structure results

in excessive profit extraction from the scheme, negating any positive influence on bringing down medical costs.

The existing process for centrally bargained medical scheme tariffs is both flawed, inflationary, and open to special interest manipulation. It exists within a regulatory vacuum, resulting in both medical scheme and service providers engaging in a confusing set of interactions which rarely benefit the public.

Third-party administrators in restricted schemes are currently quite closely monitored, with the possibility that they could lose their contract in cases of poor service. In open schemes on the other hand, administrators are able to exert influence on the schemes to such an extent that the interests of members are given a low priority.

Table 6.1 provides a summary of factors affecting the pricing and cost of private healthcare in South Africa. It also provides a suggested 'optimal response'. Importantly, these responses do not envisage the significant use of price controls. Instead the focus is on unblocking potential constraints on the optimal functioning of the demand and supply sides of the market. It should also be noted that these proposals are provisional and provide a starting point for discussion rather than final solutions.

- Where employers play a direct oversight role in the governance of medical schemes, the interests of members are often well served. However, the development of a large open scheme environment where access to medical schemes occurs through the broker market, employer influence is indirect at best.
- Where brokers provide employers with accurate and independent advice on scheme choice, schemes will be encouraged to operate in the best interests of their members – effecting both the cost and quality of coverage. The achievement of this independence can only occur through regulatory intervention, equivalent to the measures introduced in respect of Act 90 governing incentives provided by pharmaceutical companies to doctors. The remuneration of brokers needs to occur in respect of a service contract with employers and not with the medical scheme.
- Although extensive regulation is in place to guarantee the independence of scheme management structures from both administrators and brokers, this is an area where continuous improvement will enhance the functioning of the market.
- Government needs to consider positive inducements to achieve greater employer and employee participation in the decisions made by their medical schemes. The reconfiguration of the tax subsidy framework could be considered in this regard.
- Supply-side interventions need to be considered by Government to limit the unnecessary expansion in a range of services. These include hospitals and new technology. Such interventions typically require the establishment of review committees that approve new services. Such committees already exist at a provincial level for private hospital beds. However, no such arrangement exists for expensive equipment and other areas of new technology.
- Government needs to continue and expand the policy of permitting public hospitals to compete with private hospitals. However, consideration needs to be given to the expansion of this initiative into a broader range of services, including out-of-hospital services such as chronic medication and treatment.
- Government needs to regulate the conduct of health professionals more assertively. Consideration needs to be given to more adequately resourcing the Health Professionals Council (HPC) to achieve this end.

- Act 90 currently lacks a regulatory authority to back up the legislation. Consideration needs to be given to the rapid implementation of the Medicines Control Council (MCC) as a regulatory authority outside of the civil service. In addition, the Pricing Committee, recommended in the Act, needs to be implemented and properly supported.
- The inelastic demand for medical scheme cover opens members to the possibility of abuse by any party profiting from increased medical scheme contributions. In such circumstances regulatory intervention is needed to prevent the unfair pricing of medical scheme contributions. Countries such as Germany have successfully curtailed private health expenditure increases through regulating health fund contribution increases. These are not permitted to exceed the general inflation rate. All other healthcare prices and service supply adjust to the spending control measures.

Table 2: Summary of cost drivers within the private healthcare market and suggested solutions

	Comment	Optimal response
Medical scheme		
Restricted schemes	Schemes have strong governance, but lack the buying power to influence medical service providers. They are unable to access selective contracting arrangements except through intermediaries.	Provide mechanisms for employer schemes to group together to purchase healthcare. This combines strong governance with improved buying power.
Open schemes	Schemes have weak governance, but in a number of cases have the buying power to monopsony price. However, the weak governance structure results in excessive profit extraction from the scheme, negating any positive influence on bringing down medical costs.	The governance framework operating in open schemes needs to be strengthened to remove the influence of administrators and related parties.
Central bargaining of tariffs	The existing process for centrally determining medical scheme tariffs is flawed, inflationary, and open to special interest manipulation. It exists within a regulatory vacuum, resulting in both medical scheme and service providers engaging in a confusing set of interactions which rarely benefit the public.	Government needs to consider the creation of a regulated central bargaining process, which permits schemes and service providers to agree on annual fee-for-service charges. Government should participate in this process and approve the final (official) prices. Provision should be made for medical schemes to bargain individually, outside of this framework, where the resulting prices are lower than the official prices.
Third-party administrators		
Restricted schemes	Administrators are currently quite closely monitored, with the possibility that they could lose their contract in cases of poor service.	
Open schemes	Administrators are able to exert influence on the schemes to such an extent that the interests of members are given a low priority.	Problems with administrator influence can best be addressed through a continued strengthening of the governance framework of medical schemes.
Group members	Employers tend to abdicate their influence on medical schemes and consequently become price takers in the market. They are excessively influenced by brokers who operate in the interests of third-party administrators.	Incentives need to be provided in the market for medical scheme cover to ensure direct employer participation in medical scheme governance.

	Comment	Optimal response
Individual members	Individual purchasers of medical scheme cover have no market power, and are excessively influenced by brokers.	See recommendations on brokers.
Group brokers	Brokers targeting employer groups rely on large payments from administrators for their remuneration. As the employers do not directly pay for broker services, brokers serve the administrator interests. As a consequence, employers are not advised correctly on options in the market. Brokers are also in a position to bargain up commissions to attract membership.	The linkage between administrators and brokers needs to be severed. To ensure the most effective market, remuneration needs to derive entirely from contracts with employers. Kickbacks to brokers should be outlawed.
Individual brokers	Brokers targeting individual members are remunerated by administrators and not the members they are placing. As a consequence their advice is not independent, and administrators are forced to bargain up commissions to attract membership.	Members need to have the ability to access a medical scheme without using a broker. Members not using a broker should receive a discount on contributions for the commissions not paid. A contract should exist between the member and the broker.
Supply		
Hospitals	An effective cartel exists which colludes to prevent shifts away from fee-for-service billing to selective contracting. Pharmaceutical costs passing though hospitals are a major cost-driver which has little to do with the ex-manufacturer price. Hospitals obtain substantial discounts from manufacturers, which are not passed on to patients.	The cartel needs to be broken through the application of competition legislation and direct government support for competing low-cost hospitals. Restrictions on the expansion of private hospital beds should remain in operation. A certificate of need process should be introduced for applications for new hospitals.
General practitioners	General practitioners have been shifted into the out-of-pocket market. Government legislation has also limited their ability to dispense. Primary care is beginning to respond more rapidly to the emerging low-cost market. For all these reasons, primary care services are not likely to remain a major driver of cost into the future.	
Specialists	Specialists collude with hospitals to protect the fee-for-service market. They remain a significant driver of healthcare decisions within hospitals and are key to the direction costs take in the future.	The conduct of specialists needs to be placed under greater scrutiny. Horizontal collusion amongst specialists, and vertical collusion with hospitals should be outlawed.

	Comment	Optimal response
Pharmaceuticals	The pharmaceutical market is rife with kickbacks directed at the key agents making healthcare decisions, the doctor and specialist. Although new legislation has been introduced to weaken this link, give the pervasive nature of the practice, it may continue nevertheless.	Interventions in the pharmaceutical market are complex. Act 90 provides some possibility for intervention, but lacks the regulations for a compulsory license. Parallel importation of drugs within the private sector should be permitted, as well as greater scrutiny given to abuses of patent rights. However, the greatest impact on prices may emerge through demand-side interventions - in particular permitting the public sector to on-sell tender purchased drugs into the private sector. This will permit medical schemes to benefit from the government's ability to monopsony price as a the largest single purchaser of drugs in the country.
Equipment	New technology enters the market without any review for cost-effectiveness. Given the nature of the market, with demand almost guaranteed, new technology enters the market at a high price and utilisation is induced by doctors and specialists given specific financial incentives to do so.	A technology review process for both the public and private sector is required. This should scrutinize all proposed imports or purchases of equipment. If the equipment is found to be over priced, or not cost-effective, it should not receive a license to operate in South Africa.

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