'Paying more for less'

In this issue of *SAMJ* we publish an important analysis of the Competition Commission Health Market Inquiry (HMI) Report.[1] In it, Solanki *et al.*[1] provide an overview of key findings and recommendations of the HMI, highlighting key imperatives at what they call a 'critical juncture of policy development'. We all realise that private healthcare is expensive – what the Commission sought to clarify is where those costs lie and whether and how they can be controlled. In a purely market-related economy, competition is seen as a necessary and important part of any industry – in itself a controversial topic, but that discussion is not for this forum. However, the health market may, rightly, be seen as one area where competition may have different consequences in terms of costs. Indeed, Judge Sandile, Chair of the HMI panel, acknowledged that 'equitable and fair access to good quality healthcare services does not rest entirely on competition'. However, the judge also pointed out that access to healthcare is a constitutional right, guaranteed in section 27 of our Constitution. And indeed an examination of 'competition' in our relatively small but robust and very profitable private healthcare sector is important as part of a general evaluation of the state of healthcare in South Africa (SA) in the run-up to National Health Insurance and hopefully ultimately universal access to healthcare.

The focus of this inquiry was the 8.8 million people covered by private health insurance in SA. This figure is also controversial because of the implication that these are the only people who use private healthcare, when in fact we know that there are many who do not have insurance who will cover the costs of, for example, a private general practitioner out of pocket. However, it is probably safe to assume that there are very few who are willing or able to cover larger private costs such as investigations and hospital costs out of pocket. The overall conclusion of the HMI is that the private healthcare market in SA suffers from 'multiple market failures from both provider and funder perspectives', beset with problems that 'harm competition and undermine access to healthcare'. Essentially, the current system facilitates supplier-induced demand, which in turn is the 'key driver for increases in healthcare utilisation and costs'.

First, the funder market is highly concentrated, with 70% of those insured in two medical schemes (Discovery and the Government Employees Medical Scheme), and 76% of insured lives administered by two companies (Discovery and Medscheme). In addition, medical schemes offer a bewilderingly large number of products, making it very difficult for consumers to make informed choices – and the Commission found that brokers don't help much. There is also currently a large incentive for schemes to compete in areas such as attracting a younger population, which the HMI recommends should be replaced by a risk-adjustment mechanism and income cross-subsidisation to reduce the impact on scheme costs. Looking at the issue of the confusing numbers of products that schemes offer, the HMI recommends a standard package of benefits, explicitly defined and offered by all schemes, with any supplementary packages provided in a transparent manner. Here, the Commission recommends that the standard package is based on *revised* (my italics) Prescribed Minimum Benefits (PMB) to cover catastrophic expenditure and some level of out-of-hospital and primary care, which would hopefully reduce the use of expensive higher levels of care.

Another account of the HMI published by the Bhekisisa Centre for Health Journalism last year also pointed out that there are just three hospital groups – Netcare, Life Healthcare and Mediclinic – accounting for 90% of the private hospital market.[2] While on an individual level no one is questioning the commitment of the hospitals and their healthcare workers to patient care, this concentration may result in little motivation to bring down costs and little room for transformation. Currently, as openly stated by Discovery Health, medical schemes can essentially control the national price for a group's hospitals by threatening to exclude a group from a scheme's preferred providers.

Currently we have an excellent but costly private healthcare sector in SA, although it is far from always better than the public sector, depending on the disease entity and where you are in the country. However, it is increasingly unaffordable, and medical scheme costs rise year-on-year by considerably more than inflation. I would guess that most of us use a combination of a basic hospital scheme and gap cover to ensure that catastrophic costs are covered. In my experience, only those employed by large corporations that bear part of the cost have comprehensive medical cover, which has become prohibitively expensive. PMB also need urgent revision, to take into account evidence-based practice and not leave people on medications that, while adequate, are not the gold standard for care.

Solanki *et al.* rightly question the efficiency of the process used for the HMI, saying that their findings are 'neither profound nor unexpected'. However, the recommendations are important and should be acted upon.

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2. González LL. You're paying more for private healthcare and getting less, shows Competition Commission investigation. https://bhekisisa.org/article/2019-09-30-you-are-paying-more-for-private-healthcare-and-getting-less-shows-competition-commission-investigation/ (accessed 20 January 2020).

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