Explainer: How competitive is South Africa's private healthcare sector?

After a four and a half year probe initiated by South Africa's Competition Commission, a panel of independent experts released their preliminary report into the country's private healthcare market. The Conversation Africa spoke to Sharon Fonn, who was on the panel of experts, about the report.

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Why was a market inquiry set up?
The inquiry was set up because private healthcare and medical scheme cover is expensive in South Africa. Costs continue to rise and fewer people can afford it. People who have health insurance find that the scheme covers less care and they often have to pay out of pocket.

Also, the private healthcare sector consumes a large amount of the healthcare spend and resources despite the fact that it only serves a small portion of the population. The private healthcare market serves about 18% of the population who buy healthcare insurance sold by medical schemes. But the private market consumes about half of the total health spend every year.

What did you find about competition – or lack of – in the sector?

The first thing to realise is that this is a complicated market with lots of different players in it so there isn't a straightforward easy answer. It's complex.

The report talks about a funder market. What is this and what did you find?

By funders we mean the companies that purchase healthcare. This includes medical schemes, the administrators that schemes use and the managed care organisations that the schemes contract with. We found that competition doesn't operate as it should on the funder side of the market.

Basically what schemes do is pool the money that members of schemes give in premiums each month. The point of health insurance is to enable money to be pooled so that the healthy can cross-subsidise the sick. Over time it evens out.

Health insurance is there to protect people from catastrophic expenditure. Members should want their scheme to be careful and wise with their money.

Is this not happening and if not why not?

We think this isn't happening for a number of reasons. It's not to do with schemes being bad. It's about the way the market operates.

One of the reasons it's hard to know if schemes are being wise is that consumers don't have the information they need. There are about 270 different health care plans on offer from all the various medical aid schemes – each offers different cover and costs a different amount. It's very difficult to compare them and work out which option offers the best bang for a person's buck.

We have recommended that all schemes have to offer a basic package that offers the same care. Consumers could then compare like with like.

On top of this there are also regulatory problems (rules about how schemes work) where we recommend changes so that it's easier for schemes to offer a single comparable package.

So one package is one solution. But how does a person know if the quality is good or bad?

In the private market there are no measures of quality that are shared with the public. Consumers don't know if a hospital is good or bad. There is also no way to judge if care being provided by doctors and specialists is effective as there are no measures on whether or not people are better afterwards.

This can lead to more and more interventions – and a waste of money.

If data are pooled and lots of doctors and patients report about health outcomes, we can begin to know if having an extra test or some kind of intervention works. We make a recommendation about reporting on quality and outcomes.

You looked at hospitals – what did you find?

We found that is a very high level of concentration in the hospital sector. Three hospital groups dominate: Netcare, Mediclinic and Life. They have more than 80% of the hospital beds available and get 90% of all the admissions. This distorts and restricts competition.

We have made some recommendations around this. But one thing we think is essential is a supply side regulator that would, among other things, assist provinces in issuing licenses for hospitals. Some countries, like Germany, are very strict about the number of beds available in the hospital sector.

The report also talks about doctors, what did you find?

There are problems when it comes to the way doctors and specialists work. They work as individuals – not as a team. Team-based care is an internationally accepted standard because it provides better care and can be more cost effective. But our system doesn't allow this easily.

Also doctors and specialists use a fee-for-service billing model. This means they bill patients for each service they perform during a consultation. Obviously people inclined to maximise their income they will do more so they earn more. There is no good mechanism to manage this.

This is a universal problem. Different countries have different ways of managing it. In Sweden, for example, almost all specialists are salaried and paid by the state. So they don't have an incentive to do more to earn more.

There is a chapter supply induced demand. What's that about?

Basically it means that when some additional care is offered (increased access), additional use of the service that would not have otherwise have happened takes place.

This has two consequences: wasteful expenditure and patients being over serviced.

**How does South Africa compare to other countries? **

When it comes to the private healthcare sector South Africa faces a problem of over-servicing and over supplying. Three examples illustrate this.

Firstly, hospital admission rates are extremely high. South Africa's rate was higher than all but two of 17 other OECD countries we used as comparisons.

We also looked at seven different surgical procedures. In four, South Africa had the highest usage rates.

Lastly we looked at the number of people that get admitted to intensive care units. We found that South Africa had higher admission rates than eight other countries with comparable published data.

What will it take to break the current patterns?

We recommend that the regulatory regime needs to be improved. Regulators aren't as sensitive to competition issues as they could be. South Africa has laws in place but they aren't being fully used. Stewardship from the Department of Health has also been weak.

But we were also very aware that there is no quick fix. The market is incredibly complex. This means that several interrelated interventions are needed. Market failures will persist if the recommendations aren't introduced as a package.

We also kept in mind that the country is trying to move towards a system of universal health coverage and we have been mindful not to undermine that vision.

What, in summary are your main recommendations?

- The way in which schemes operate needs to change. This should include the way options are structured so that people can compare apples with apples. We hope that will improve accountability in the funder market.
- More transparency: a system needs to be put in place that allows people to see what value they're getting for what they're paying for.
- Greater competition, especially in the hospital sector is needed.