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THE REGULATORY REGIME – IMPACT ON COMPETITION AND ON COSTS

Anthony Norton

Introduction – scope of the inquiry

- Subject matter of the inquiry (paragraph 5 of the Terms of Reference) – evidence-based inquiry to *"to determine **the factors that restrict, prevent or distort competition** and underlie increases in private healthcare prices and expenditure in South Africa".*
- In paragraph 69 of the Statement of Issues, the Panel notes:

  "*Possible deficiencies and unintended consequences in the regulatory framework may distort competition, raise barriers to entry and expansion, and maintain and/or create positions of market power.* ***The Panel wishes to understand the current regulatory framework and how it affects competitive outcomes****."*

Introduction – scope of the inquiry

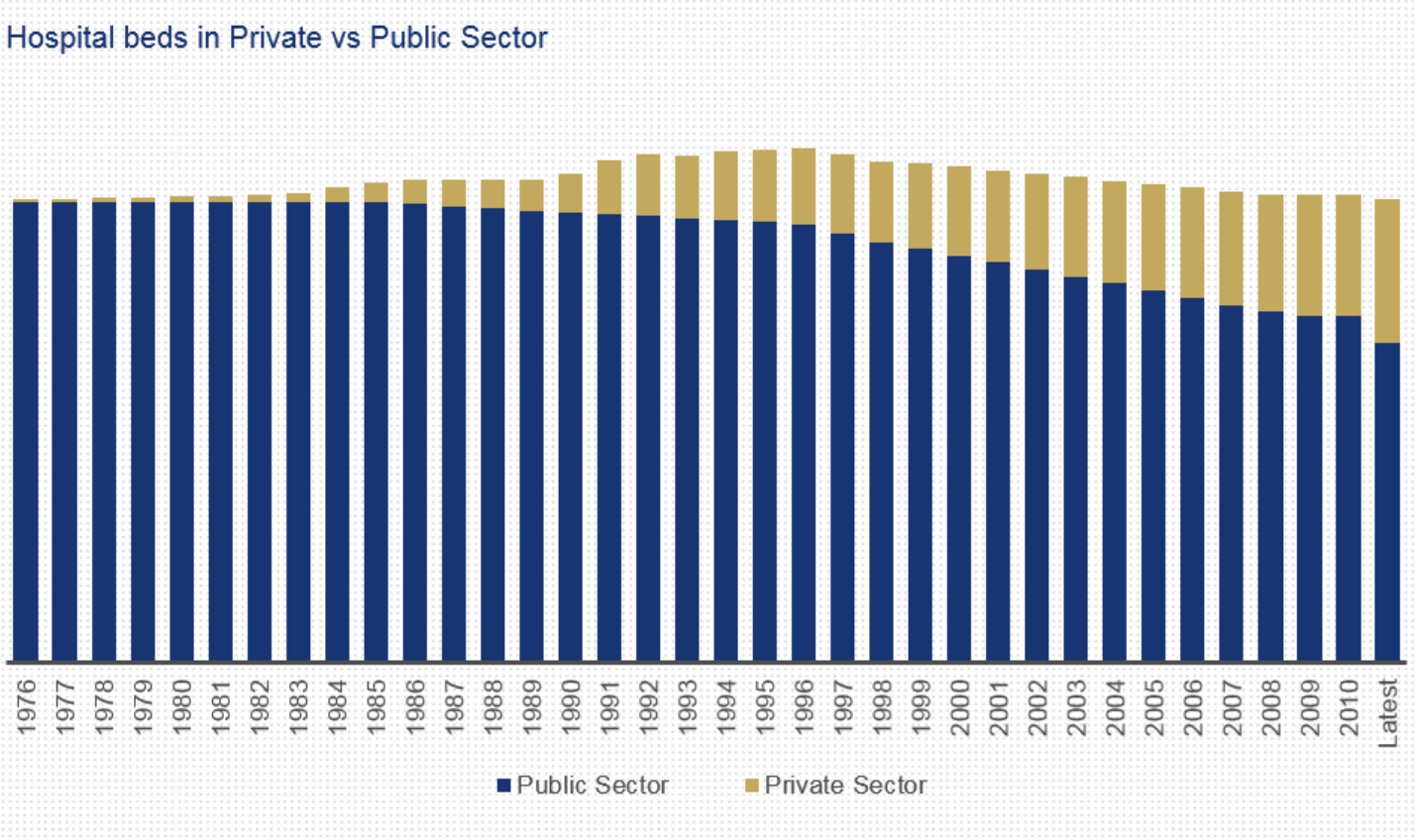
- Inquiry not about determining the precise scope of sections 8, 27 and 28 of the Constitution, nor a general inquiry into the state of private healthcare.

- Range of very complex policy issues relating to healthcare, including NHI, etc. which the Panel will not be in a position to definitively determine given the limited scope of the inquiry and the time available to it to make its findings.

Challenges facing the provision of healthcare in South Africa

- The current South African regulatory regime governing private healthcare needs to be considered against the backdrop of the current challenges facing healthcare in South Africa being:
  - A high and increasing quadruple burden of disease and an ageing population within medical schemes;
  - Significant reduction in the number of beds in the public sector notwithstanding population growth and severe challenges facing public healthcare;
  - A chronic shortage of medical professionals including nurses and doctors (particularly specialists) in both the public and private sector; and
  - An inflexible and inefficient regulatory and administrative regime (including the HPCSA) that constrains innovation, limits competition and results in increased costs and prevents hospitals from being able to be able to react quickly to increased demand.

Challenges facing the provision of healthcare in South Africa



Source: A v D Heever, 2008 National Health system. *A Roadmap for Reform* – Reference DOH 2005 hospital bed data

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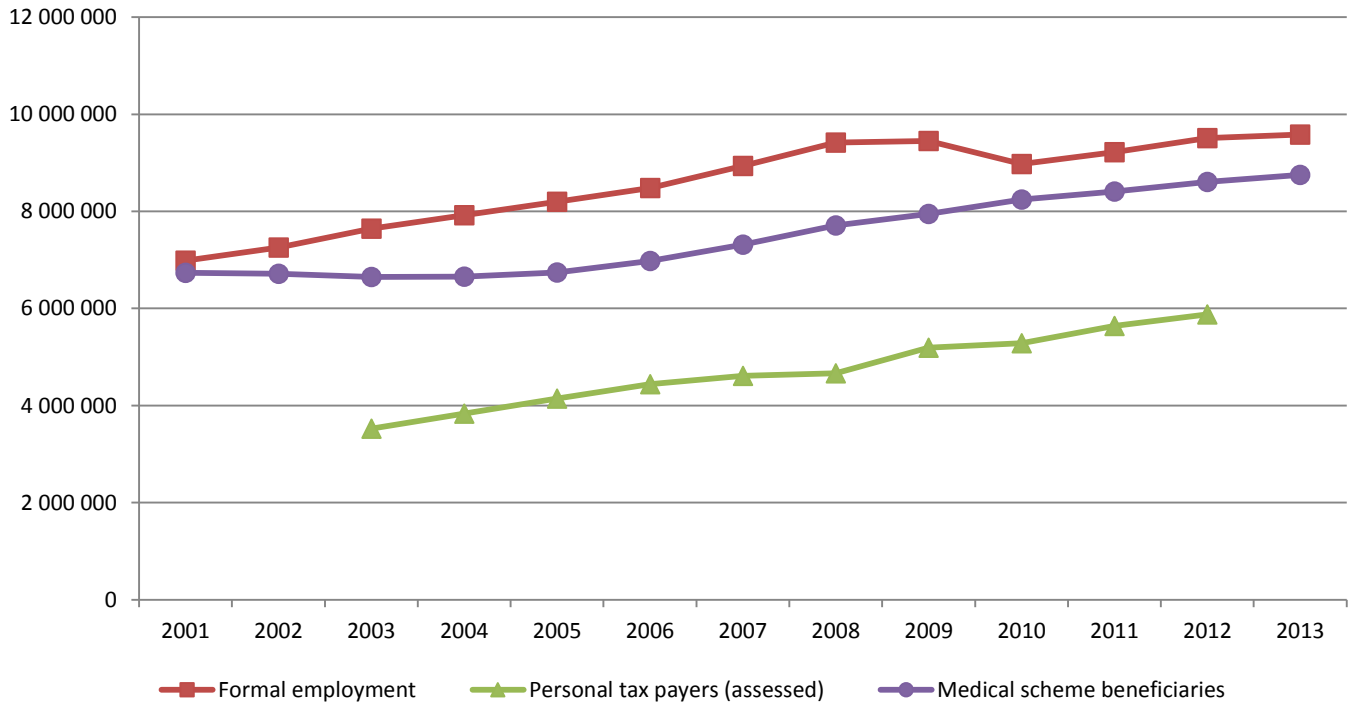
Background – Key features of private healthcare in South Africa

- The South African private hospital sector is characterised by significant investment into new facilities and equipment, a number of new entrants and a highly competitive environment.
- There was an increase of more than 2 million medical scheme beneficiaries in the period 2001 to 2013.
- Principal membership of schemes closely linked to employment.
- Regulation of the private sector by various public bodies.

Medical scheme membership and population coverage



Source: CMS Annual Reports, StatsSA Labour force surveys, National Treasury tax statistics

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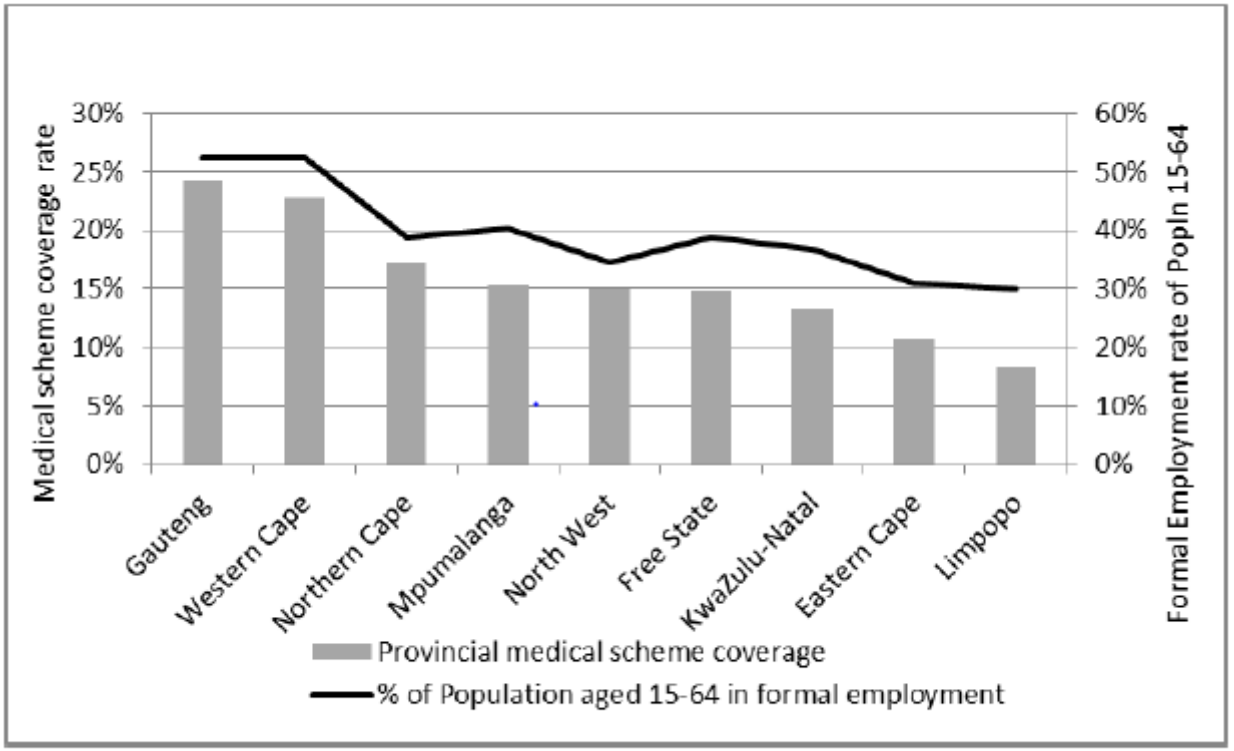
Medical scheme coverage rate by province



Source: CMS annual report 2012, Labour Force Survey 2012

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Reasons for increase in private healthcare expenditure

- The principal industry role players all appear to be in agreement that inflation and increases in utilisation are some of the primary reasons for the increase in private healthcare expenditure.
- Discovery Health Submission 17 Nov 2014 (page 7):

*"**Drivers of medical scheme premium increases***

- Premium increases are driven by 3 main factors: claims inflation, NHE inflation and reserve building.

- Claims inflation accounts for almost the full extent to which medical premium inflation exceeds CPI. Solvency requirements also contribute to inflationary pressure, while NHE are deflationary."

Reasons for increase in private healthcare expenditure

- Discovery Health Submission 17 Nov 2014 (page 8):

  *"**Drivers of claims inflation**…*

  - 63.2% of the excess inflation is due to increases in volume as a result of demand side factors (2.9% out of 4.6%)

  - 27.9% of the excess inflation is due to increases in volume as a result of supply side factors (1.3% out of 4.6%)

  - 8.9% of the excess inflation is due to tariff increases exceeding CPI (0.4% out of 4.6%)

  ***Annual tariff increases are therefore a minor factor** in explaining the difference between CPI and annual premium increases. Over 90% of this difference is attributable to **increases in volume of services** consumed by scheme members each year, due to both demand and supply side factors, **with demand side factors being by far the most important**".*

Reasons for increase in private healthcare expenditure

- Medscheme submission dated October 2014 (Page 14):

  "The average increase in claims expenditure (expressed per scheme member per month) has been 10.9% p.a. for all Medscheme client schemes since 2008. Of this average increase:

  *- **5.5% is explained by CPI inflation;***

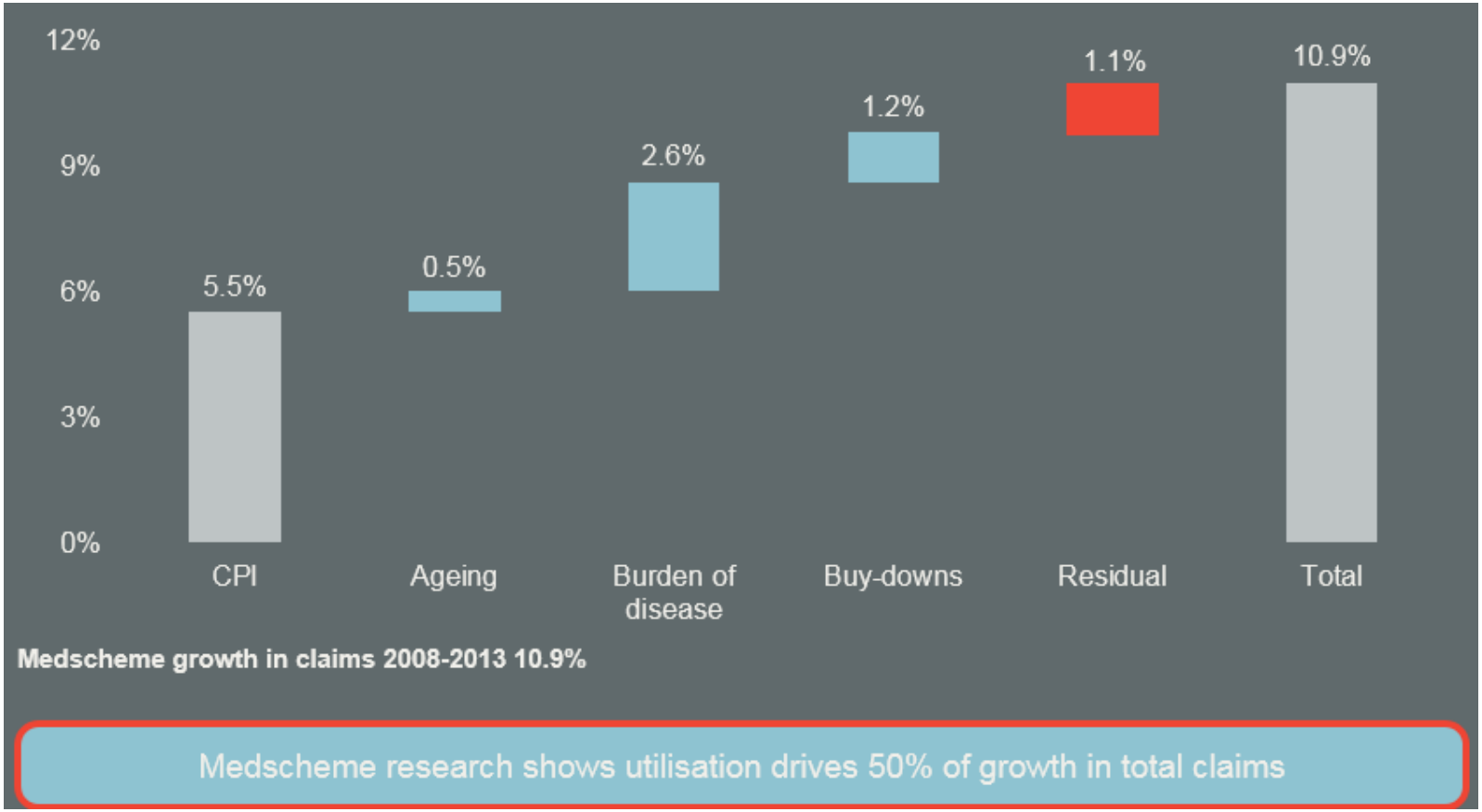
  - 0.5% is explained by ageing…;

  *- **2.6%** is explained **by an increased burden of disease…;***

  - An additional 1.2% is due to buy-down behaviour…;

  *- **This leaves a 1.1% residual**."*

Risk profile: Attribution of total healthcare "inflation" : Medscheme



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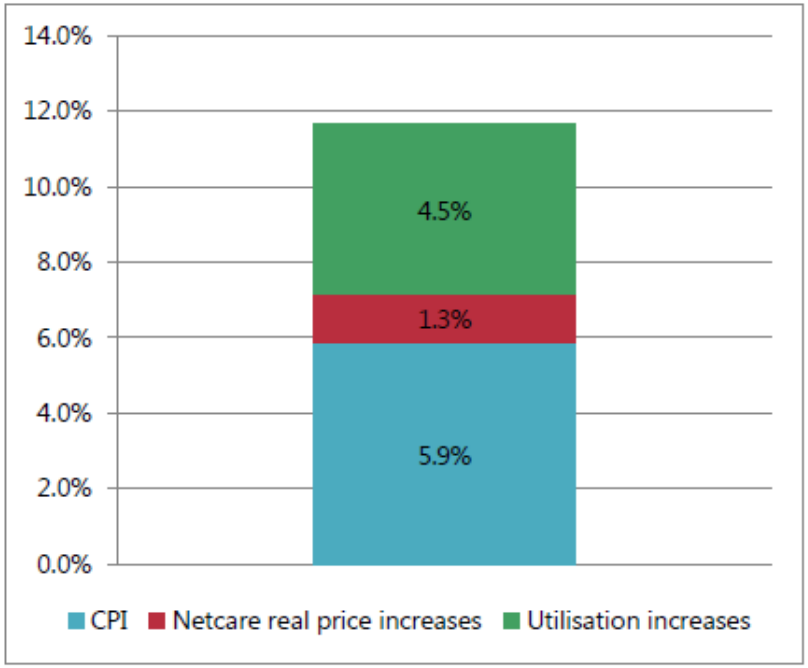
Reasons for increase in private healthcare expenditure

- Contribution to hospital expenditure per life per month increases over time:



Source: Stats SA, CMS Annual Reports, Netcare data

Figure 62: Insight submission dated 31 October 2014 (page 102)

Reasons for increase in private healthcare expenditure

- Netcare submission dated 31 October 2014 (page 54):

  "While hospital price increases have generally been above CPI over the last 10 years, this can be explained by the fact that real hospital price inflation tends to exceed CPI. This result is a consequence of key input costs, such as nursing salaries, electricity, rates and taxes etc. generally increasing at a rate above CPI."

Impact of the regulatory regime

- Private hospitals and other healthcare professionals required to operate within the parameters and constraints of the current regulatory framework.
- As a consequence of the existing regulatory regime, there are certain additional costs and inefficiencies which arise, which are beyond the control of private hospitals.
- Existing regulations restrict efficiencies:
  - Private hospitals cannot employ doctors.
  - Private hospitals cannot source medicines in the most cost-effective manner.
  - Private hospitals cannot train doctors and are restricted in certain provinces in the number of nurses which they can train.
  - Private hospitals cannot add additional beds or build new hospitals without prior regulatory approval.

Focus of this presentation – intersection of public and private

- Regulation of private healthcare by the State is multi-faceted and impacts the private sector in a number of material respects:

  – Regulation of medical schemes – Medical Schemes Act of 1998;
  – Regulation of private hospitals – National Health Act and Regulation R158*; and
  – Regulation of doctors and nurses – Health Professions Act and Nursing Act.

(* Regulation R187 in the Western Cape)

PART 1

MEDICAL SCHEMES LEGISLATION

Regulation of medical schemes – inadvertent consequences

- The New Medical Schemes Act (commenced in 2000) introduced social solidarity principles.
- One of the consequences is that these principles restrict the extent of competition between the schemes:
  - open enrolment – anyone can join;
  - community rating - contributions may not differ depending on, for example, age or health status; and
  - PMBs - defined set of conditions required to be covered by all schemes.
- The New Medical Schemes Act also introduced fixed regulatory solvency ratios.

Regulation of medical schemes – inadvertent consequences

- Originally intended that social solidarity principles would be balanced by further regulatory reform including mandatory membership.
- These would reduce cost of membership and address the risk of anti-selection, i.e. old and unhealthy are incentivised to join schemes, young and healthy not incentivised to do so.
- Also intended to introduce progressive solvency requirements which would reduce costs of medical schemes.
- This has not yet occurred.

Statutory solvency requirements

- Current solvency requirements effectively require medical schemes to hold 25% of gross contribution income in reserve.
- Inflexible - solvency ratio is not directly related to the risk faced by schemes ie. it does not take account of:
  - size;
  - risk profile;
  - whether the scheme is making a surplus or deficit; or
  - re-insurance or capitation arrangements.
- Inflexible 25% insolvency requirement results in some schemes holding more than is required and others too little.

Statutory solvency requirements

- Approximately 8.6% in increases in contributions from 2001 – 2004 were driven by solvency requirements.

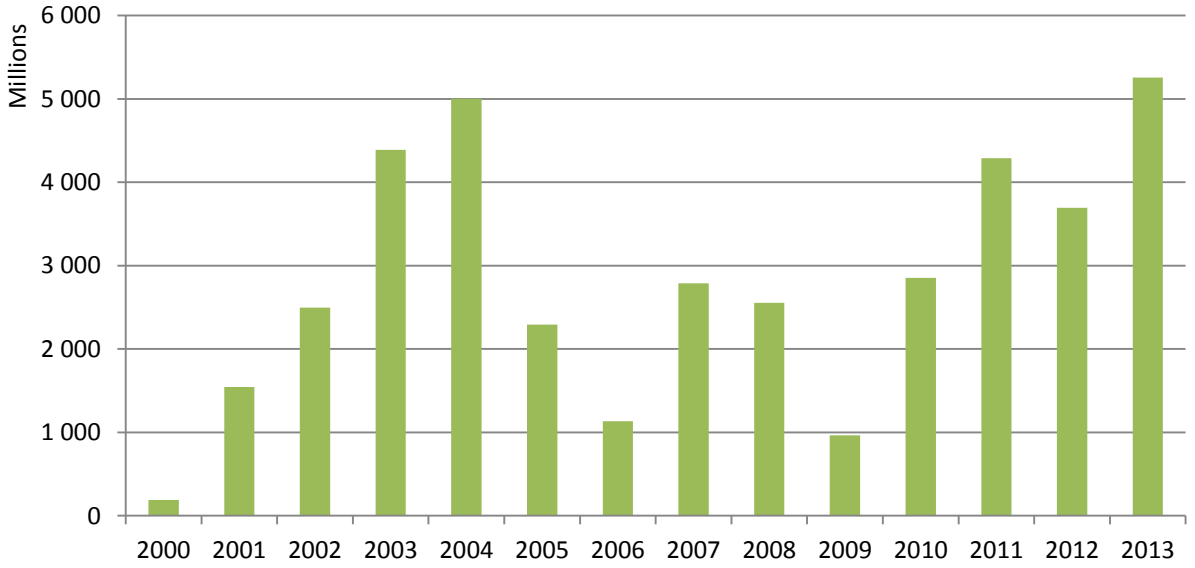
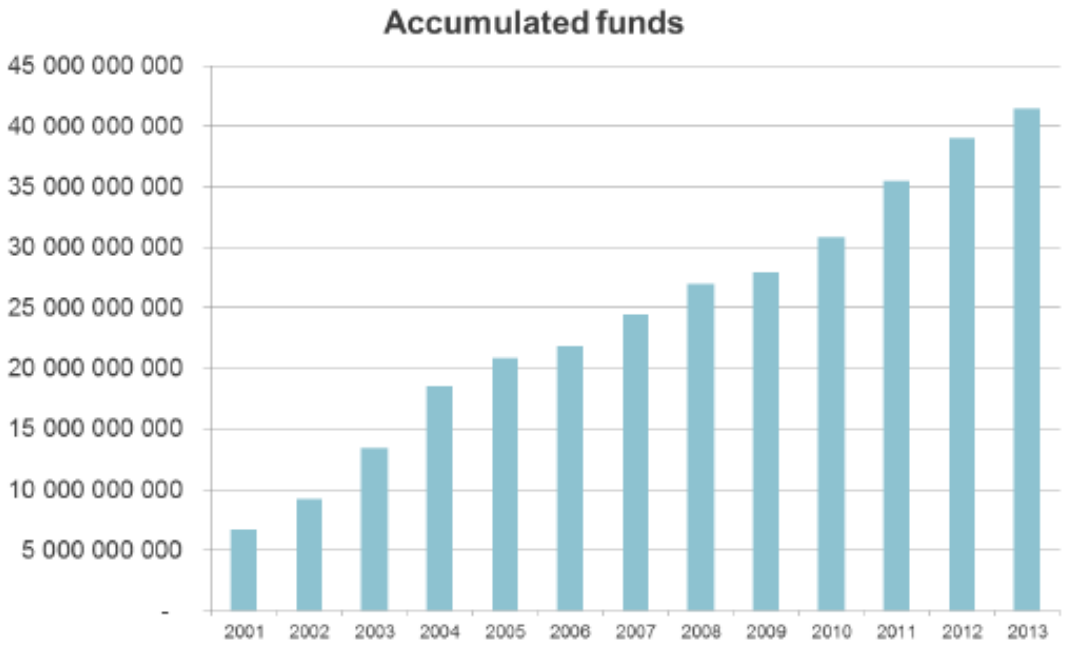


Figure 39: Insight report of 31 October 2014: Aggregate medical scheme net surplus results by year.

Statutory solvency requirements



Accumulated reserves of medical schemes (page 44 of Netcare's regulatory paper).

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Statutory solvency requirements

- Work by Ganz suggests that there should be an aggregate solvency ratio of 12% across medical schemes.
- If this is applied to CMS 2013 data – there is considerable excess in medical scheme reserves (in excess of R28 billion).
- Medical scheme excess solvency.

Accumulated Reserves 2013	44 300 149 000
GCI 2013	129 788 790 000
Average Solvency 2013	34%
Industry reserve requirement (25%)	32 447 197 500
Ganz require solvency (12%)	15 574 654 800
Excess in Reserves	28 725 494 200

Figure 44: Insight paper of 31 October 2014

Statutory solvency requirements

- Inflexible solvency ratios also restrict competitive threat from new schemes.
  - A growing scheme will have to build up solvency ratios.
  - These will have to be funded through higher contributions.
  - Counter-intuitively, a declining scheme will require a smaller contribution to maintain its solvency requirements.
  - Has the effect of punishing a growing scheme.
  - A barrier to entry to new schemes.

Anti-selection or adverse selection

- Open enrolment and community rating preclude schemes from differentiating between low-risk and high-risk beneficiaries.
- Creates incentive for younger, healthier people only to join when they are older, become ill or see a clear need for health services, for example, childbirth.
- Anti-selective behaviour leads to a deteriorating risk profile within medical schemes which in turn leads to higher costs for beneficiaries of the schemes, making the scheme less attractive (actuarial death spiral).

Anti-selection or adverse selection

- Proportion of the total population, those above the threshold, and medical scheme beneficiaries by age: (shows anti-selection).

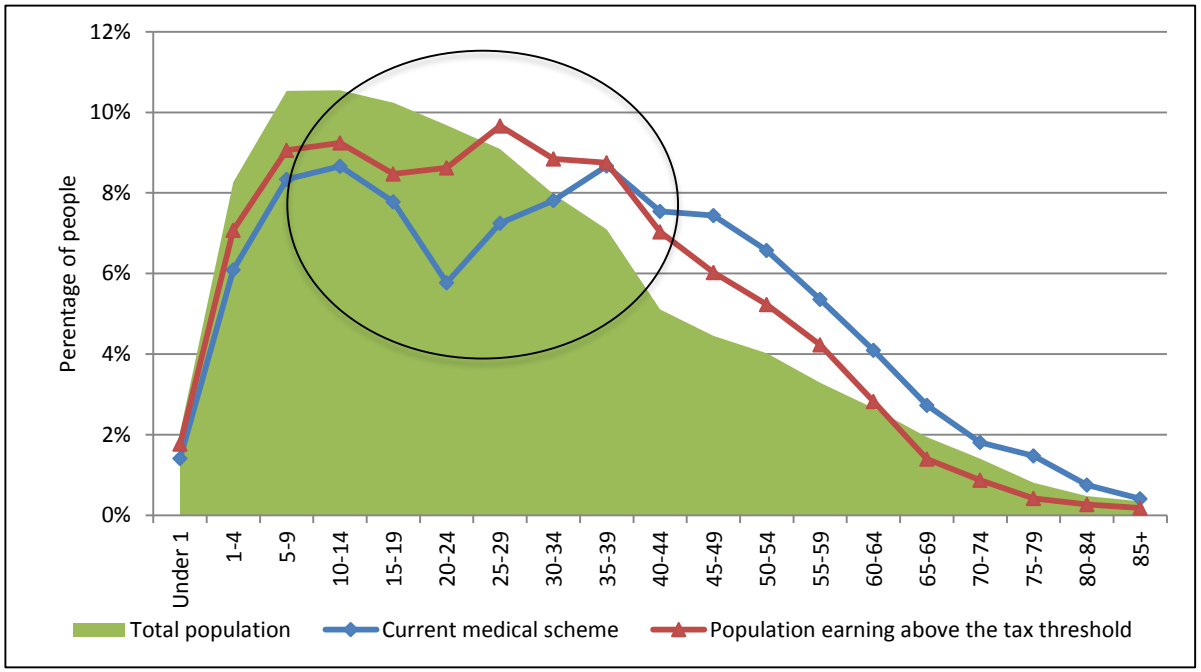

Figure 27: Insight paper of 31 October 2014

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Anti-selection or adverse selection

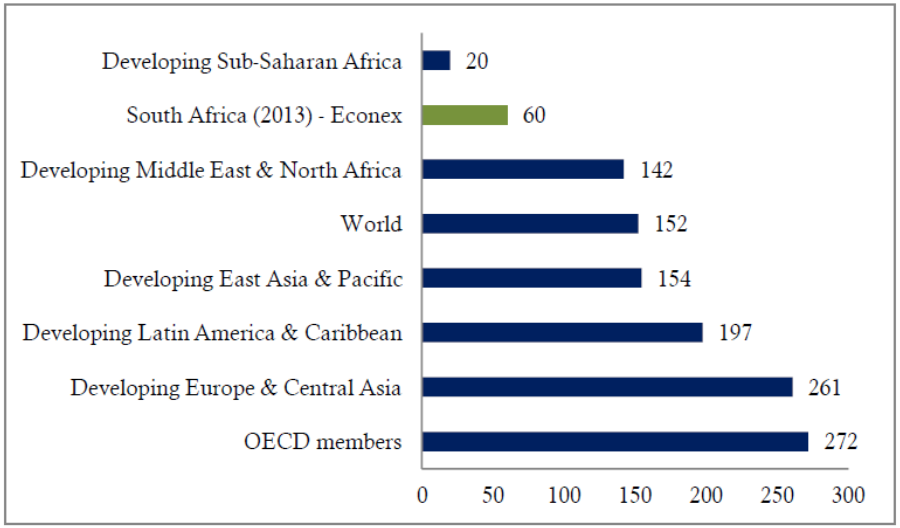
- Insight has calculated that: "[a]*lmost 2% of cost increases per annum in Prescribed Minimum Benefit total costs can be attributed to ageing membership and chronic disease profile changes.*"
- Addressing adverse selection improves the risk profile and, according to ordinary insurance principles, an improved risk profile decreases the cost of membership for each member.
- Could be achieved through mandatory membership requirement.

PART 2

SHORTAGE OF DOCTORS

Severe shortage of doctors

- There is currently a severe shortage of doctors (particularly specialists) in South Africa and this is reflected in a paper published by Econex in August 2015.
- Regional comparison – all doctors per 100 000 citizens (2010 or latest available year)

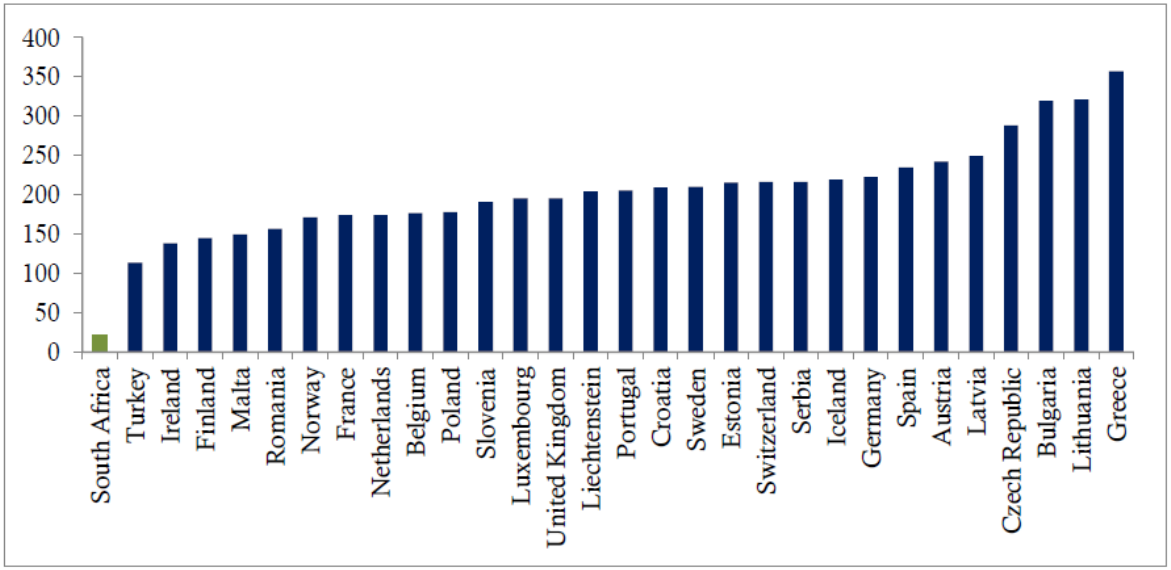


Source: World Health Organisation, 2014[11]

Figure 5: Econex paper of 26 August 2015

Severe shortage of doctors - specialists

- Number of specialists* per 100 000 citizens in developed countries and South Africa (2011):



Source: Eurostat, 2015; Econex, 2014

Figure 7: Econex paper of 26 August 2015

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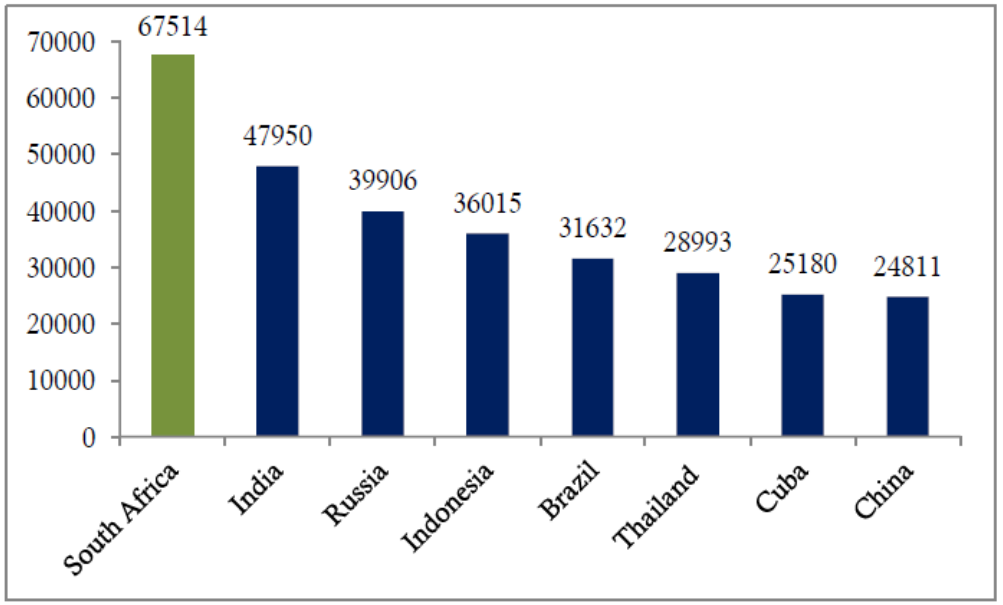
Severe shortage of doctors

- The comparative shortage of doctors should be seen against the backdrop of South Africa's high burden of disease.
- Age standardised DALYs per 100 000 citizens (2012)



Source: World Health Organisation, 2014[16]

Figure 9: Econex paper of 26 August 2015

DOH response to submissions made to the Healthcare Market Inquiry

- "*The Department recognises the many challenges that exist within the Human Resources for Health realm, not just in relation to the training and recruitment of doctors, but* ***the entire spectrum of health professionals required to deal with the population's epidemiological needs****. This is why as early as October 2011, the Department published the Human resources for Health Strategy document as a guide to action with the immediate effect of having to undertake a range of activities, make new policies, develop new programmes, make detailed staffing plans for new service strategies and manage our health care workforce in ways that motivate them to provide quality heath care."* (page 15)

DOH response to submissions made to the Healthcare Market Inquiry

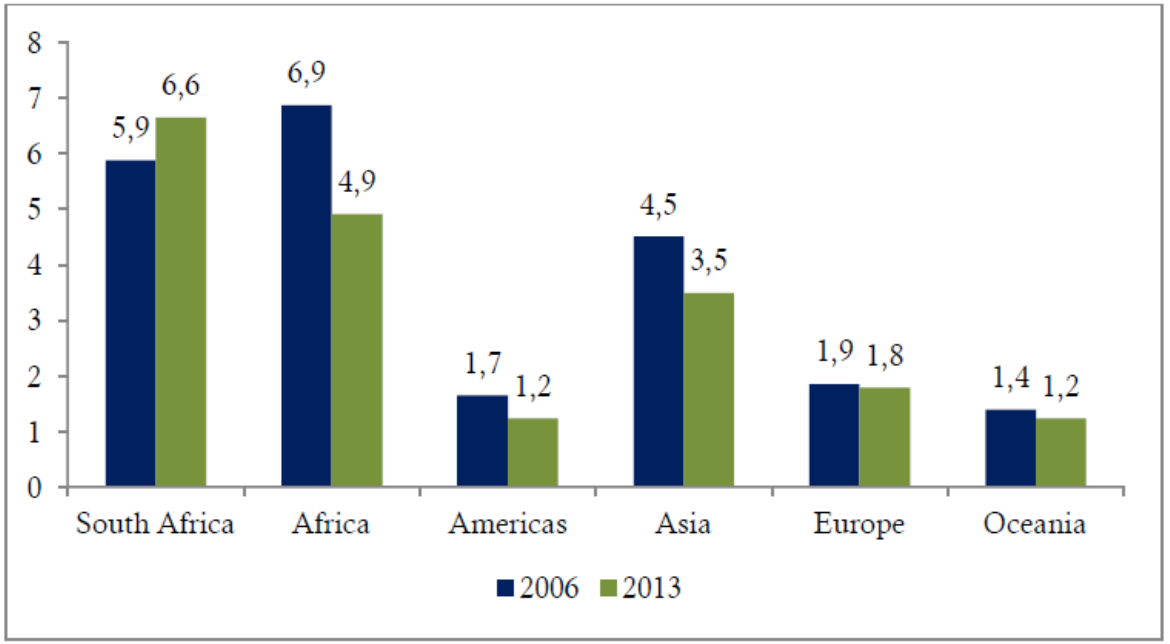
- *"The Department notes that health professionals are highly skilled and, like other skilled professionals, very mobile. The migration of foreign health professionals in and out of South Africa needs to be managed."* (page 16)

Insufficient medical training capacity

- South Africa produces a limited number of medical graduates per year. (Approximately 1400 per annum. This has remained constant for several decades while the population and burden of disease have 'exploded'.)
- In 2006 the DOH suggested increasing the number of graduates from 1300 to 2400 – this has not yet occurred.
- The increase in the South African population means that the population ratio to medical schools is increasing, whereas it is decreasing in other countries or regions.

Insufficient medical training capacity

- Population per medical school, 2006 and 2013 (millions).



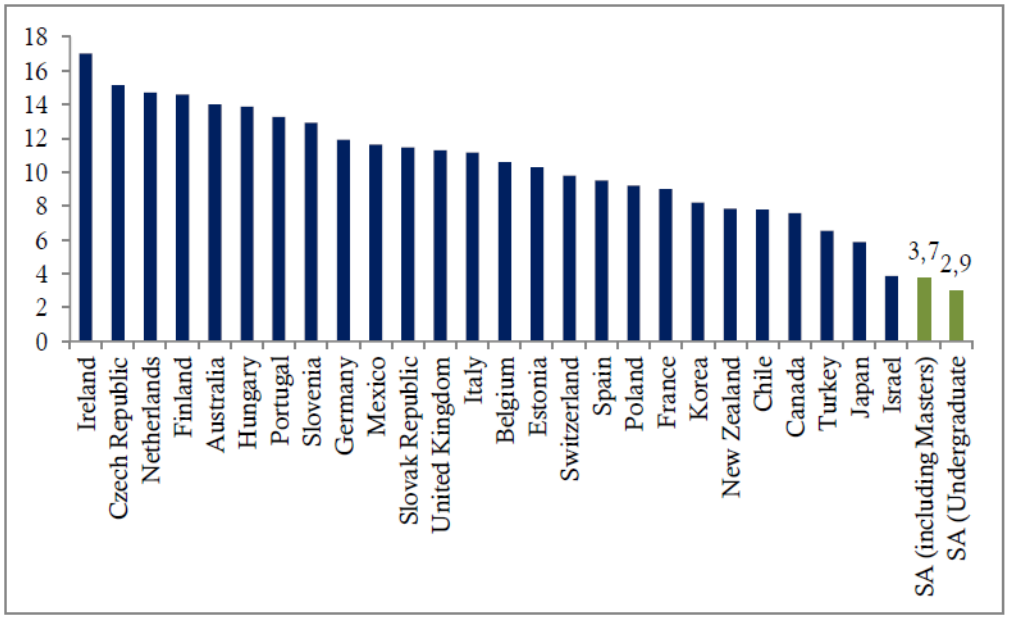
Source: Boulet et al. (2007); Duviviers et al. (2014)

Figure 13: Econex paper of 26 August 2015

Insufficient medical training capacity

- Graduates* per 100 000 citizens in OECD countries and SA, 2012

(*Graduates are defined by the OECD as "*the number of students who have graduated from medical schools or similar institutions in a given year. Dental, public health and epidemiology graduates are excluded*". For South Africa, the number of students graduating with Bachelor degrees from South Africa's eight faculties of medicine at public universities in 2012 was used.)



Source: OECD, 2015; HEMIS, 2014; World Bank, 2010

Figure 14: Econex paper of 26 August 2015

Insufficient medical training capacity

- There are currently no accredited private medical training facilities in South Africa despite growing demand for doctors and places at existing universities are hopelessly over-subscribed.
- In addition, except for limited pilot projects, the private sector is precluded from providing clinical training at their facilities.
- This should be compared to India and Brazil:
  - In India, 50% of medical graduates are from private medical schools; and
  - In Brazil, more than half of medical schools are private.
- There are a number of other countries that encourage private medical schools, such as Columbia, Mauritius, the United States and the Dominican Republic.

Restriction on foreign practitioners

- Processes for foreign healthcare practitioners to obtain permission to work in South Africa are very opaque.
- In broad terms, applicants are required to engage in the following four application processes:
  - verification of educational qualifications and training through the Education Commission for Foreign Medical Graduates : International Credentials Services;
  - letters of endorsement from the DOH required at various stages of the registration process;
  - registration to practise medicine in South Africa through the HPCSA; and
  - permit to work in SA through the Department of Home Affairs.
- It is common for applicants to experience very lengthy delays in the processing of their applications and often no feedback is provided to applicants.

DOH response to submissions made to the Healthcare Market Inquiry

- The submissions by the Department of Health appear not to differ from the submissions made by hospital groups (see page 16). The position of the Department appears:

  "*As indicated in the Human Resources for Health Strategy document (section 3.1.12, p 32): "an instrument for managing the supply of the health workforce is the management of the recruitment of foreign trained health professionals. Current national NDoH policy is to* ***limit recruitment of foreign doctors to a maximum of 6% of the medical workforce*** *and only to use country-to-country agreements. There are currently 3,004 foreign doctors in South Africa (approximately 10% of the medical workforce)".*

  Priority has been given to recruitment of Cuban doctors for South Africa and training of medical students in Cuba, based on bilateral government-to-government agreement." (page 16)

Restriction on employment of doctors

- Corporate entities are effectively precluded from employing doctors or the formation of multidisciplinary practices.
- These prohibitions restrict the development of innovative ways to address challenges of fragmentation of care.
- Allowing hospitals to employ doctors may allow for more efficient collaboration between doctors and healthcare facilities (eg. scheduling, cost containment, etc.)
- Kaiser Permanente in the USA is an example of such an innovative approach to the provision of healthcare.

HPCSA is dysfunctional

- The Minister appointed a Ministerial Task Team to investigate "*allegations of administrative irregularities, mismanagement and poor governance*" at the HPCSA.
- On 9 October 2015 the Task Team presented a report to the Minister.
- The Executive Summary of the report noted that the Task Team had been appointed because of complaints relating to:
  - poor communication;
  - **prolonged delays in processing applications**;
  - unfair processes in professional registration; and
  - failure to provide guidance in resolving challenges.

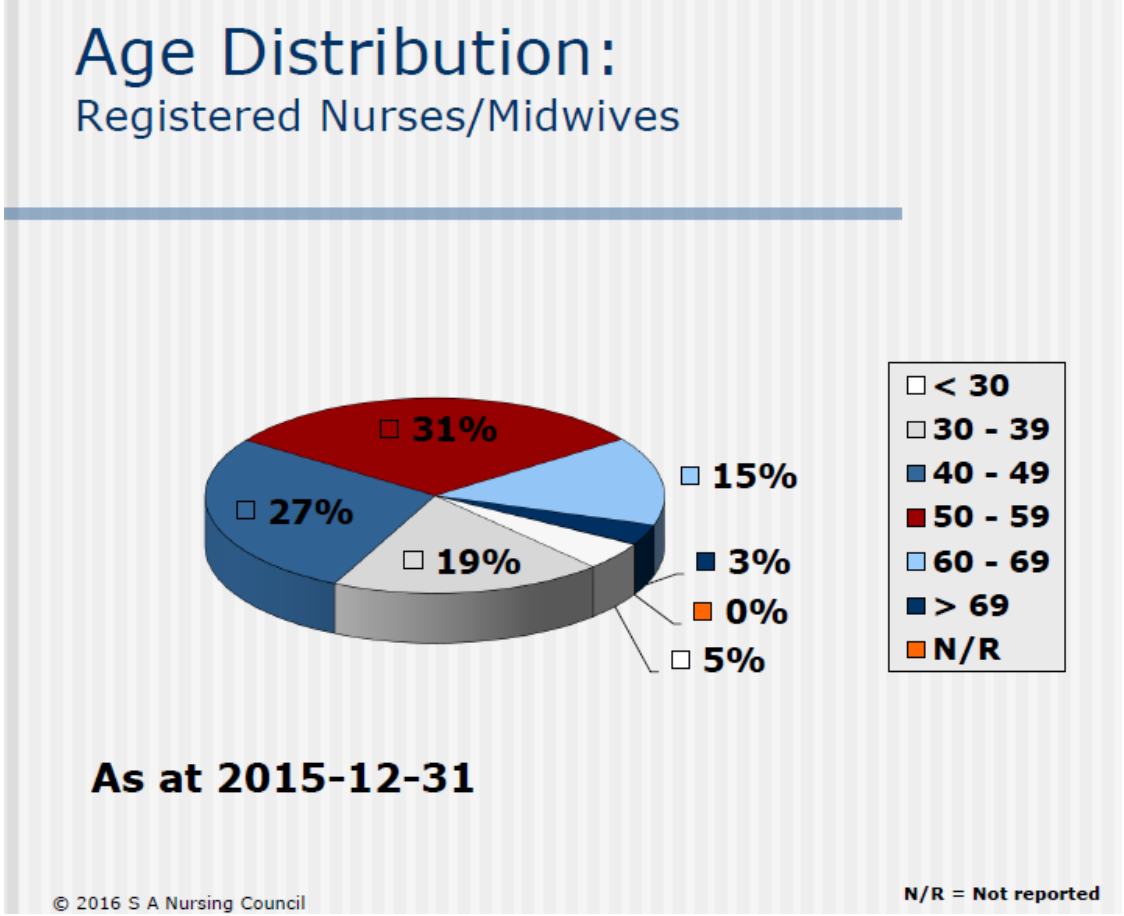
HPCSA is dysfunctional

- The Task Team found, *inter alia,* that:
  - "*The key themes…reflect the failure of the HPCSA to carry out its statutory mandate in its core five functions of (1) registration of health professionals, (2)* ***examination and recognition of foreign qualifications of practitioners****, (3)* ***professional conduct enquiries,*** *(4)* ***approval of programmes in training schools,*** *and (5) continued professional development.*"
  - "*The HPCSA is in a state of* ***multi-system organisational dysfunction*** *which is resulting in the failure of the organisation to deliver effectively and efficiently on its primary objects and functions in terms of the Health Professions Act 56 of 1974.*"

Shortage of nurses

- There is a global shortage of nurses.
- In South Africa, the shortage is somewhat more acute – one of the reasons being the historical closure of public nursing colleges (which have subsequently re-opened) and the limitation of private training of nurses.
- Not only is there a shortage of nurses in South Africa, but the average age of nurses is also high.
- Owing to the shortage of nurses nursing salaries tend to be high.

Shortage of nurses



Shortage of nurses

- The private sector is permitted to train certain types of nurses, but the regulators have also in certain provinces limited the number of nurses the private sector may train.
- Netcare has 5 nursing training campuses – in 2015 it had more than **3,400** students.
- The Nursing Council has limited the number of nurses Netcare can train in certain provinces. Absent these restrictions, Netcare could train up to an additional 400 – 500 nurses per year.

Shortage of nurses

- Restrictions on the employment of foreign nurses:
  - foreign nurses must go through a 10 step process in order to work in either the public or private sector;
  - it can take between 2 and 10 years for a foreign professional to obtain permission to work in South Africa; and
  - they are required to pass compulsory practical exams even in respect of nurses coming from developed nations such as the European Union.
- Netcare attempted to recruit qualified nurses from India and found the administrative processes to be very onerous.

DOH response to submissions made to the Healthcare Market Inquiry

- *"However, it is agreed that better partnerships and **involvement of public private interactions must be considered more strategically** as part of the broader programme of health system strengthening and capacity building. Under such an arrangement, government will have to ensure there is adequately regulated oversight for the private sector in relation to training of nurses and the skills set that they graduate with."* (page 14)
- *"The process of planning improvements in HRH is guided by the National Department of Health's 10 Point Plan which incorporates human resources planning, development and management as one of the priorities **(includes for example Re-opening of nursing schools and colleges)**. Strengthening the health service training platforms (Academic Health Complexes, Nursing Colleges, Ambulance Colleges) is a priority for the HRH SA Strategy."* (page 14)

PART 3

SURGICALS, MEDICAL DEVICES AND MEDICINES

Surgicals, medical devices and medicines

- Approximately 25-30% of medical scheme expenditure in respect of Netcare is in respect of surgicals, medical devices and medicines.
- Medical devices and surgicals are charged at cost price.
- Medicines are charged at the single exit price, in terms of the current regulatory regime (no dispensing fee is charged).
- There is a significant price differential using a 2011 analysis performed by Netcare (using data from 2010) comparing medicines obtained by its UK subsidiary compared to domestic prices of the same medicines. The weighted average cost was significantly higher in SA between the prices at which Netcare is able to procure medicines in SA as compared to the UK.
- If Netcare were able to freely source medicines internationally, this could potentially result in significant cost reductions, based on international benchmarks.
- The DOH appears to agree that there is room for further efficiency gains in this regard (page 10).

Surgicals, medical devices and medicines

- UK benchmarking in 2011 (using 2010 pricing) showed glaring disparities in drug pricing:

	Netcare R'value (VAT incl)	BMI R'value (adjusted for VAT)	South African price premium
Product A	1 501,54	76,27	1 869%
Product B	515,28	240,11	115%
Product C	1 942,87	1 808,44	7%
Product D	751,92	251,42	199%
Product E	516,24	208,96	147%
Product F	5 451,12	1 885,68	189%
Product G	303,31	309,81	-2%
Product H	493,83	404,23	22%
Product I	716,40	964,35	-26%
Product J	1469,32	1 159,34	27%

PART 4

HOSPITAL LICENSING

Cumbersome regulatory framework

- Cumbersome and inefficient regulatory framework increases costs and limits scope for competition.
- In India – low cost facilities owing to low regulatory requirements for buildings.
- In contrast, in South Africa – extensive minimum standards in terms of Notice 158.
- Failure to comply with minimum standards can result in withdrawal of licence even if no clinical risk arising from failure to comply.
- Question is whether all of the minimum requirements are still appropriate or whether they simply increase the costs of construction.

Hospital licensing

- Challenges of the current licensing regime:
  - Licensing applications apply to new hospitals as well as expansion of existing facilities and change of use of beds.
  - Different provinces have differing processes, some of which are not consistently applied.
  - There are no statutory time periods for consideration of applications – there are numerous cases of lengthy delays in finalising applications, even for change of use applications.
- Department of Health response to submissions:

  *"The Department accepts that due to historical arrangements the licensing of private hospitals is currently characterised by a **fragmented approach** and processes that need to be better streamlined and strengthened."*

Hospital licensing

- Recommendations:
  - A transparent and consistent regulatory regime should apply throughout the country, stipulating the specific factors which the regulators should take into account in determining whether or not to approve the application for a hospital licence (or a change in bed use).
  - Specific statutory time frames should be provided for the processing of applications, with approval of the application in question being the consequence of a failure to take a decision within the stipulated period.
  - Applications should not be required for extensions of existing facilities or changes of use of beds within existing facilities.
  - Regulators should provide reasons for their decisions (in accordance with the provisions of the Promotion of Administrative Justice Act).
  - The regulatory regime should focus on ensuring that prospective facilities meet the requisite clinical standards and are able to provide the appropriate quality of care and should not involve assessments of "*necessity*" or "*need*", which are inherently investment-driven decisions.

Conclusion

- The Swedish Agency for Growth Policy Analysis, in a paper entitled Economic Effects of the Regulatory Burden, states:

"The point of departure here, is that every regulation is in itself well-intended and possibly well-justified, but these interventions in the functioning of markets and civil society, over and above purely effective regulations, more or less inadvertently ***create distortions and problems, which in turn justify new interventions, in a form of self-reinforcing spiral****.*

The argument is thus that ***many regulations impair the market system's competition****, price systems and innovative capacity, irrespective of how well-intentioned they are, which in turn creates new problems that cause new interventions."*

Conclusion

- Existing regulatory regime contributes to increased costs and inefficiencies.
- Improvements in the regulatory regime would lead to enhanced competition and lower costs.
- Improvements to the regulatory regime could result in improved access to healthcare professionals and to healthcare facilities.

Risks associated with price control

- The Competition & Markets Authority in its provisional remedies note regarding the private healthcare investigation, stated that:

  "We were concerned ***that…a price control regime would be very difficult and costly to set up in this market****…and to update, to take account of both the introduction of new treatments and procedures, and movements in costs over time. We were also concerned that price controls may be vulnerable to circumvention, in that hospitals subject to such a cap would be incentivized to reduce the quality of the service they provide. Further, we thought that the existence of price caps* ***may generate distortion risks*** *over time by discouraging innovation and the introduction of new and better treatments and procedures.* ***They would also discourage new entry****…"*

Some potential solutions to increase competition

- Increase supply of doctors through private medical schools
- Lift restrictions on how many nurses private hospitals can train
- A transparent and consistent hospital licensing process
- HPCSA must support task shifting through the registration of technicians
- Address red tape associated with registration of foreign nurses and doctors
- Applications should not be required for extensions of existing facilities or changes of use of beds