An overview of supply side problems and recommendations from the Competition Commission Health Market Inquiry and how they should be taken forward

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Background

- Competition Commission initiated Health Market Inquiry after observing sustained increases in prices and expenditure in the private health care sector which were above headline inflation.

- We were interested in the **incentives** which drive market behaviour
  - What reward / punishment mechanisms make stakeholders behave the way they do?

- Is this behaviour conducive to achieving **positive outcomes**?
  - Positive outcomes are those that benefit **consumers**
  - E.g. competition on price, quality, and health-outcomes

Conduct of the Health Market Inquiry

- The HMI is the first evidence based process in South Africa that carefully gathered evidence and studied the private healthcare market.
- Our investigation included over
  - 43-million individual patient records
  - 11-million admissions
  - specially commissioned studies
  - numerous written submissions
  - public hearings and seminars
- The inquiry focused its investigation on hospitals, doctors, and funders

Findings - Facilities

- National level three big hospital groups dominate the market (83.1% - beds & 86.9% - admissions) and the majority of local markets (60%) are also highly concentrated
  - Consistent and sustained profits by three large hospital groups
  - No meaningful disruptive entry, in spite of the high number of licenses in issue
- Drs bring in patients to hospitals – the big three can attract Drs more easily – hospitals benefit from and facilitate high admission rates
- Excess bed capacity in the private sector
- Bilateral negotiations between funders and facilities is practical
  - Smaller number of negotiators (schemes / administrators / facility groups)
  - Negotiations are largely characterised by FFS tariff increases rather than on alternative reimbursement models
  - Facility networks result in competition and lower prices / costs
  - Limited pressure from DHMS (and DH) and lately GEMS
  - No measures of quality

Findings - Practitioners

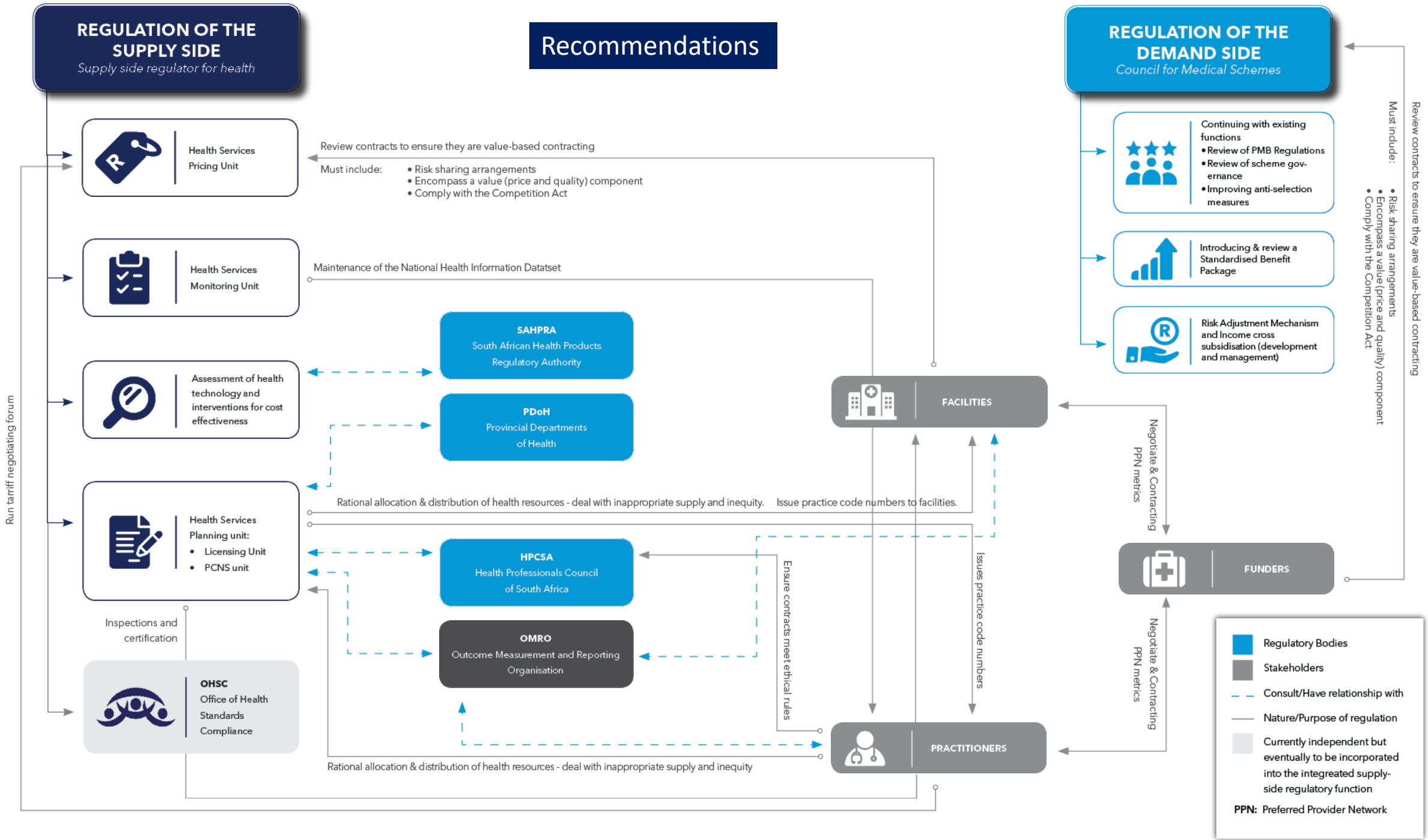
- No reliable database of practitioners
- Innovative models (in particular multi disciplinary teams) are hampered by:
  - Funders
  - Practitioner Associations
  - HPCSA Rules
- “Price vacuum” (CC ruling on collective bargaining) but too many funders and practitioners for individual negotiations to be practical
  - Out-of-date codes and unilateral code changes
  - Practitioner associations quasi-collusive
- No standardised measurement of quality and health outcomes
  - Consumers are uninformed and cannot compare
  - Practitioners cannot benchmark
  - Funders cannot contract on quality
- There is excessive utilisation driving healthcare costs
  - Not necessarily improving outcomes
  - More practitioners → more admissions
  - Current market incentives promote overutilization
    - FFS
    - Reimbursement of PMBs at cost - shifted market power to practitioners who ‘up-code’ and can set their own reimbursement level
    - Hospi-centric benefit design

Funders – Findings

- Unique feature of the South African private market not for profit schemes are administered by for profit administrators
- Funders market is highly concentrated
  - 22 open medical schemes, two medical schemes constitute approximately 70% total open medical scheme market
  - Discovery Health Medical Scheme comprises 55%, and GEMS is the largest restricted scheme
  - 16 medical scheme administrators, Discovery Health and Medscheme account for 76 %
  - No meaningful entry
- Sustained levels of profitability have been found across the funder market
- Discovery Health has, over sustained period of time earned profits that are multiple of those of its main competitors
- Incomplete regulatory framework → Competition on risk (risk rating)
- Schemes have failed to manage supply induced demand and demand almost no accountability from administrators
- Lack of accountability of schemes to members
- POs and some Trustees receive remuneration regardless of scheme performance
- Administrators appear to not be disciplined by their schemes

regulatory framework

- Four critical areas
  - Healthcare capacity planning and related information to guide rational and need-based investment in facilities and human resources for health
  - Economic value assessments of new technology and interventions
  - Implementation of appropriate pricing mechanisms where the market fails
  - Reliable information on the quality and outcomes of healthcare services


REGULATION OF THE SUPPLY SIDE
Supply side regulator for health
Recommendations
REGULATION OF THE DEMAND SIDE
Council for Medical Schemes
Health Services Pricing Unit
Review contracts to ensure they are value-based contracting
Must include:
• Risk sharing arrangements
• Encompass a value (price and quality) component
• Comply with the Competition Act
Health Services Monitoring Unit
Maintenance of the National Health Information Datatset
SAHPRA
South African Health Products Regulatory Authority
Assessment of health technology and interventions for cost effectiveness
PDoH
Provincial Departments of Health
Health Services Planning unit:
• Licensing Unit
• PCNS unit
Rational allocation & distribution of health resources - deal with inappropriate supply and inequity.
Issue practice code numbers to facilities.
HPCSA
Health Professionals Council of South Africa
OMRO
Outcome Measurement and Reporting Organisation
Inspections and certification
OHSC
Office of Health Standards Compliance
Rational allocation & distribution of health resources - deal with inappropriate supply and inequity
Run tariff negotiating forum
FACILITIES
PRACTITIONERS
FUNDERS
Continuing with existing functions
• Review of PMB Regulations
• Review of scheme gov-ernance
• Improving anti-selection measures
Introducing & review a Standardised Benefit Package
Risk Adjustment Mechanism and Income cross subsidisation (development and management)
Must include:
• Risk sharing arrangements
• Encompass a value (price and quality) component
• Comply with the Competition Act
Review contracts to ensure they are value-based contracting
Negotiate & Contracting PPN metrics
Negotiate & Contracting PPN metrics
Ensure contracts meet ethical rules
Issues practice code numbers
Regulatory Bodies
Stakeholders
Consult/Have relationship with
Nature/Purpose of regulation
Currently independent but eventually to be incorporated into the integreated supply-side regulatory function
PPN: Preferred Provider Network

Motivation for a New Independent Supply side regulator

- Independence is important in a market where there are concerns
  - Regulatory capture
  - Regulatory failure
  - Lack of stewardship
- Independence has been critical to the success
  - Thailand's National Health Security Office
  - The National Institute for Health and Care Excellence (NICE)
- Supply side regulator should have its own board
  - Appointed by the Minister
  - Following a transparent public nomination process

1. Health Services Planning Unit

- Clear needs-based, licencing regime which factors in competition assessments
    - Guided by national policy
    - In consultation with provincial departments which will have monitoring responsibilities
- CC to review approach to creeping mergers to address high levels of concentration
    - Need to have a more strategic / longer-term view on hospital mergers

2. Health services pricing

- Multilateral tariff negotiation forum wherein funders and practitioners can collectively negotiate
  - Under the auspices of the SSRH
  - Set maximum PMB prices
  - Subsequent value and risk-based bilateral negotiations are supported
  - Important – allows for shared information
- Funders and facilities to continue with bilateral negotiations; but not business as usual
  - Within three years FFS contracts replaced with ARMs
  - These contracts to be submitted to CMS/SSRH for vetting

Practitioners – Recommendations

- CC and HMI Guidance to practitioner associations on conduct; Separate business and academic functions
- Incentivise practitioners by linking billing number to various reporting requirements
- HPCSA to update learning curriculum
- HPCSA to review ethical rules regarding:
  - Multi-disciplinary practices, fee-sharing, and employment of doctors

OMRO Outcomes Monitoring & Reporting Organisation

- Not a regulator, private enterprise/platform
- Drs and patients report on outcome
- Allow providers to benchmark and improve
- Provide patients and funders information regarding quality
- Initially voluntary, progress to mandatory

Relevance to NHI

- Full implementation of NHI is still several years away - 2026 at the earliest
  - Private sector will continue to operate
  - Fixing incentives in the private sector is a **necessary step** towards successful NHI implementation
- A more competitive private sector will have lower costs, prices, and greater value-for-money
  - Greater competition and efficiency will benefit state purchaser of services
- NHI requires supply-side providers to be properly regulated – SSRH
  - Purchasing and monitoring requires oversight
  - International example of the UK NHS single-purchaser system has public and private providers regulated by:
    - Monitor - independent supply-side regulator
    - Competition Authorities
- The NHI fund negotiations should be done under the auspices of the Competition Act

Relevance to NHI

- Risk Adjustment Mechanism will create a single risk-pool – ready to merge
- Outcomes Monitoring and Reporting Organisation will allow for value purchasing
- Multilateral Negotiating Forum sets a useful forum for price negotiation is for price determination and enforces sharing of information
- Licencing and accreditation of service providers – 100% consistent with NHI
- Supply Side Regulator will start data collection and oversee information sharing