COSATU SUBMISSION TO COMPETITION COMMISSION MARKET INQUIRY INTO PRIVATE HEALTH CARE COSTS
OCTOBER 2014

"A preventative health scheme shall be run by the state.
Free medical care and hospitalisation shell be provided for all, with special care for mothers and young children." ***Freedom Charter***

"Because of the burden associated with paying for health services at the time of illness, in the long term we are committed to the provision of free health care at the point of service for all citizens of South Africa" – ***A National Health Plan or South Africa (ANC 1994)***

"All over the place, from popular culture to the propaganda system, there is constant pressure to make people feel they are helpless, that the only role they can have is to ratify decisions and to consume". ***Noam Chomsky***

1. Introduction

The importance of the task facing the panel of the Market Inquiry into the private healthcare sector cannot be sufficiently stressed. It is very likely that the outcomes will be used for informing the future legislative framework for the National Health Insurance (NHI). It is therefore necessary that the outcomes support the ultimate aim of the proposed NHI. The panel must be guided by the vision of the NHI as confirmed by the millions of voters who voted in the current fifth administration – a publicly funded and publicly administered single-payer system that acts as administrator or payer and, as a single "insurance pool", that would receive all health care funds and pay out all health care costs for all our people. It is this vision that is supported by COSATU.

We would respectfully remind the panel of the words of the Minister of Health, Dr Aaron Motsoaledi, in the run up to the establishment of the current Competition Commission (CC) Market Inquiry. He stated that the "***artificially high private health-care costs need to come down as one of the two major conditions necessary for the successful implementation of the NHI*"**. And he said further "***I can only say one thing: This is a revolution to bring justice to the poor. And revolutions happen in a way that may not be pretty. This is war. This is for the population to see how greed is fought. It's naked, naked greed from powerful individuals who want a good life for themselves and a poor life for anybody else***".

At the outset, we would repeat some questions which we posed at the time of the development of the Terms of Reference (TORs) for this inquiry, and trust that these will be covered in the final report.

Scope

a. How far will the investigation go?
b. How will this be used in future healthcare planning?
c. What are the intentions of this process both for healthcare planning and legislative processes in the period between now and when NHI may be implemented?
d. How does this affect the present status of the setting / benchmarking of tariffs as contemplated by the National Health Act (NHA) – and more specifically the role of the National Department of Health (NDoH) in setting the guideline National Reference Price List (NRPL)?

Enforceability

a. Will the findings be enforceable - we have all witnessed that little has changed in previous inquiries such as the Bank Charges Inquiry?
b. What becomes of this process?
c. Does it play a role in future legislative planning – and what of current legislative processes that are pending and before parliament even before this report will be available?

Health Costs

a. What is the structure for the determination of costs, vis-à-vis Designated Service Provider (DSP) agreements? How are these regulated? Is there potential for competition infringements? How could these DSP agreements contribute to medical scheme monopolies and ensure bigger market volume?
b. What is the specialists' role in ensuring user traffic to designated hospital and the room for improper incentive schemes?
c. How does the system of tariff costs and non-tariff costs impact on users?
d. How do "In-Hospital Costs" impact on users, especially for
    i. Pathology & Radiology
    ii. Consumables
    iii. Medicines

Non-Health Costs

a. What are these / how are they composed?
b. How are these reported in medical aid financials?
c. How "marketing costs" & "broker fees" & "co-administration costs" impact on pricing structures?
d. Should there be a benchmark or regulated factor for non-health cost?

2. Background

Those who argue for a free market in health care should respond to the millions of sick and desperate people the world over who die simply because they cannot get access to health care. There is no better example than the health care system in the United States.

The effect of the loss of medical cover of elderly people living in the United States on their retirement is common knowledge, particularly after the release of the film by Michael Moore - "Sicko". The loss of jobs in the United States meant that a greater number of citizens of that country confront the double crisis of losing their jobs and their employer-sponsored medical aid which covers 177 million people. A recent study by the Robert Wood Johnson Foundation (2013) indicated that the number of uninsured could jump to as much as 65 million in 10 years as health care costs double.

South Africa has one of the most skewed and unequal health systems in the world – not too different from the free market model of the US (RWJF Survey: 2013).

In 2007, the spending patterns of the health sector are evidence of this:

- 14.8 percent of the population is covered by medical schemes and able to source most of their health services in the private sector. The per capita annual expenditure on this group, combining both medical expenditure and out-of-pocket expenditure was approximately R9 500 per beneficiary in 2007.
- A further 21% of the population are not covered by schemes, and use the private sector on an out-of-pocket basis spending the equivalent to almost R1 500.
- The remaining 64.3% of the population is entirely dependent on the public sector for all their health services with less than R1 300 spent person for government primary care and hospital services.

By early 2014 the situation had not changed, and this is highlighted in the Twenty Year Review which states that:

> *"Although South Africa spends about 8.5 percent of GDP on healthcare, the country has poor health outcomes, compared with other countries with similar, and in certain instances lower, national income and health expenditure per capita. This is attributed to two main factors. The first is the gross inequality where 5 percent of GDP is spent on 16 percent of the population while the remaining 3.5 percent of GDP is spent on 84 percent of the population. The second factor is the high cost of healthcare in the private sector." (Presidency 2014: 61).*

3. Constitutional Imperative : Right to health care

The grim reality though is that a huge percentage of the country's population does not have equal access to healthcare.

We will argue that a major factor that must be addressed in this inquiry is the constitutional right of access to essential health care services, and that the state must take ***"reasonable legislative and other measures within its available resources to achieve the progressive realisation of these rights".*** (RSA 1996: Section 27 (a)).

The Statement of Issues (SOI) does indicate that access to health services and care is a constitutional socio-economic right, but the focus in the guidelines is on harm to competition; rather than the extent to which strengthening of competition will achieve the realisation of this right and what factors in the market, other than competition between suppliers of healthcare goods and services limit access by the users of the services.

We acknowledge the role and function of the CC is to promote competition. However, this must be fulfilled within the broader context of the South African constitutional framework and Bill of Rights. Private health providers are not just offering ordinary goods and services, but are involved in an area with clear constitutional significance.

The CC must not lose sight of the weaknesses of competition in this particular market. There will be factors other than competition which have a bearing on this inquiry, and these operate in conjunction with market principles and competition to influence the state of the private healthcare environment.

If competition interferes with or impedes access to health care services, even those within the private health sector, or interventions or recommendations by the CC have these effects, then such action is inconsistent with the constitution and therefore invalid. The constitutional court has stated that there is, at the very least, negative obligation placed on

the state and all other entities and persons to desist from preventing or impairing the right of access.

The private health care market is not homogenous and both the SOI and the TORs attempt to break it down into three categories of health financing, providers and consumers. In order to understand fully the market dynamics in these areas it is critical to further break down each of these into specifics, eg health financiers – medical aids, health insurance, brokers, administrators, regulatory bodies (Council for Medical Schemes, Financial Services Board / Treasury, Board of Health Care Funders, etc.). Each of these stakeholders plays specific roles and has specific interests, and the inquiry should seek to investigate if their activities "harm" the social objectives (versus market competition). It is these specific activities and interests that must be aligned towards improving health outcomes through say NHI or other public purpose programmes that seek to address Section 27 of our constitution.

4. Underlying theoretical perspective

The peculiar nature of healthcare sectors worldwide means that market mechanisms are often inadequate to ensure efficient and equitable functioning.

The profit motive driving the private sector, such as over-charging by practitioners and hospitals and the year-on-year exorbitant increases in medical aid fees, is contrary to our perspective that as health is a public good, that quality health care should not be commercialised and be beyond the reach of all people. The World Health Organization Report of 2008 identifies commercialisation as one of the key factors which prevents nations from reaching their health policy goals. It states "***commercialisation has consequences for both quality and access to care. The reasons are straightforward: the provider has knowledge; the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient***" (WHO 2008:14).

It is clear that the CC conceptualises competition within the confines of a neoliberal outlook. This paradigm argues that increased competition in any market is essential for efficiency, and that this market-led efficiency should be prioritised over socio-economic objectives such as universal health insurance.

We believe that there is an underlying assumption in documents from the CC that perfect competition or that the strengthening of competition is the best solution to the problem of high prices in the private health care sector, and that a perfectly working private health care market will lead to better reasonable costs and expenditure, and health outcomes. We base this on the statement in the TORs which indicate that the inquiry will probe the increases private health care sector holistically "to determine the factors that restrict, prevent or distort competition and underlie increases in private health care prices and expenditure in South Africa".

As we have pointed out in previous submissions, COSATU rejects the argument that increased competition in any market is essential for efficiency. Health care markets inherently fail because of the nature of the healthcare market - there is the problem of information asymmetry between providers and users, and providers have to act as perfect agents for users of services - in reality this never obtains. In addition, the presence of third party payers such as medical aid and health insurance create problems of moral hazard

(supplier induced demand or over servicing-unnecessary diagnostics, poly-pharmacy and repeat visits, etc.). Therefore, markets must be managed to achieve specific social or normative objectives - such as achieving universal coverage.

The outcomes in the report of the enquiry must be aligned to this and not achieving a perfect market. Otherwise, if, for example the proposed theory of harm, which refers to barriers to entry and expansion at various levels of the healthcare value chain is applied, we believe that there is a danger that its findings and recommendations will be geared towards strengthening of competition in the private health sector and not on the realisation of the right to access affordable health care.

It has been acknowledged within literature, that free market principles which rely on the notion that competition is the most equitable and rational means of distributing products and services are not effective within the health care context. Private healthcare costs in South Africa are characterised by soaring costs borne by consumers while private hospitals and medical specialists enjoy enormous profits.

In our view, at the heart of the challenges facing our health sector is a two-tier contradictory and wasteful health care funding system. On the one hand, there is a public health care system which treats health as a social need, but faces inadequate funding and resources.

The public health sector with less than 40% total health care resources serves 83% of the population, which is mostly black and poor. Whereas the private health sector which treats health care as a commodity and accounts for more than 60% of the total health care resources but serves a minority of the population, which is mainly white and wealthy.

This is the system which the Minister of Health, Aaron Motsoaledi, recently described at a conference of the Hospital Association of South Africa (HASA) when he said "The main problem bedevilling the country's health system is the funding structure that favours the rich over the poor". The state has attempted to address this challenge cited by the minister through regulation. In the following section we examine the effectiveness of state regulation in the private health sector.

5. The Regulatory framework

5.1 Coordination and Regulatory Paradigm

The literature indicates that the post-apartheid government has not regulated the private health sector effectively. Harrison (2009:25) attributes this failure to inadequate policy coordination and a weak regulatory framework. This has produced negative socio-economic outcomes such as the over-supply of services (DBSA 2008:24). The private health care market is characterized by information asymmetry, which allows health service providers to manipulate the diagnosis process in order to generate extra profits. This then results in users paying large amounts of money for health care services which they don't necessarily need.

According to Bloom et al (2008:2077), this challenge cannot be addressed by market inventions. He argues that non-market institutions are the only effective mechanisms for decreasing negative practices such as over-supply. Interventions such as standard setting and creating clear detailed regulatory frameworks are crucial for altering the unequal

knowledge power relations in the health sector. In other words, market mechanisms cannot resolve information asymmetry. The solution to this problem is not increasing market efficiency and competitiveness. It should rather be based on creating a capable developmental state— which uses its institutional power— to direct provider-user relations towards achieving the goal of affordable health care.

Another short fall of regulation in the post-apartheid era has been the over-emphasis on efficiency. The post-apartheid regulatory regime has been driven by the key assumptions of economic liberalism. According to this school of thought, the primary aim of regulation is to promote competitiveness and efficiency. McIntryre and Gilson explain (2002:1638) that health policy regulation has been solely guided by the goal of efficiency. Minimal attention has been paid to social equity and equal access. The sentiment of these authors is echoed by the South African Medical Journal (SAMA 2012:772) which argues that: **"competition regulators clearly treat healthcare as a commodity governed by free-market rules**".

5.2 State, Markets and Regulatory Power

This regulatory challenge has been exacerbated by the CC ruling in 2004. Prior to 2004, the private healthcare sector practised collective bargaining and published jointly determined tariffs. This continued unhindered between the medical schemes and various healthcare providers with oversight from three industry associations, namely the Board of Healthcare Funders (BHF), the South African Medical Association (SAMA) and the HASA. The problem seen at the time by the Commission was that the act of collective bargaining, joint determination of tariffs, and the publication thereof, amounted to price fixing; a contravention of section 4(1)(b)(i) of the Act. In light of this seeming collusion, it was deemed necessary to outlaw such practices, which took place in 2004.

This intervention seemed justifiable at the time. However, some studies point out that it increased costs in the private sector, especially for specialised services (DBSA 2008; SAMJ 2012). This challenge of price/tariff regulation has also been negatively affected by the minimal role of the state in price determination. This is unacceptable, especially when the excessive fees charged by this sector are taken into account. As argued earlier, the country's health challenges cannot be addressed using market mechanisms. Private health care providers are primarily concerned about profit and returns on investments. Therefore, we cannot rely on the market to increase access by creating a just pricing system. The Department of Health (DoH) should re-introduce the National Health Reference Price List (NHRPL). It is noteworthy that the court ruling abandoning the published 2010 NHRPL did not in any way prevent the DoH from following the correct procedure and re-establishing the NHRPL.

Prescribed Minimum Benefits (PMB) legislation indicates that medical aids must pay costs on an unlimited basis for PMB-classified condition. This was intended to protect members from out-of-pocket payments. But the legislation fails to indicate what the minimum of this tariff should be, creating a wonderful money-spinning opportunity for some health care providers, particularly private hospitals and specialists. Subsequent to the decision of the CC in 2004 – some specialists bill schemes in excess of 300% of acceptable tariffs. Medical scheme members may not be aware of this until after the claim has been incurred and can lead to catastrophic financial expenditure – just the opposite of what was the original intention of the PMB legislation.

5.3 Poor Implementation

In addition to the above, the state has not implemented previous legislation effectively. For example, The Certificate of Need (CON), which formed a crucial part of the National Health Act (2003) has not been implemented (Harrison 2009:25). This section of the act empowers the state to regulate the growth and economic activities of the private sector. It contains a number of provisions which could have addressed the primary cost-drivers of health. The most important of these are in section 36 and 37, which state that no citizen can build a health facility, increase beds, buy technology, and provide services without the CON. More importantly, it instructs the Director General of the DoH to consider " ***the need to promote an equitable distribution and rationalization of the health service and health care resources , and correct inequities based on racial, gender, economic and geographical factors***"(RSA 2003).

The above-mentioned factors listed in section 36 are the primary drivers of costs in the sector. Van Den Heever (2000) illustrates this trend in his study on private health care costs in South Africa. Between 1988 and 2001 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).

The achievement of a competitive environment in the private health sector can never be an end in itself. What is rather required is regulatory intervention; not strong competition within the private health sector as a prerequisite for the realisation of the right of access to health care services.

The guiding principles of the report of this inquiry ought to be focusing on achieving Universal Health Care, and not about creating a perfect market because this is not possible in any case. COSATU suggests that there should be a greater regulatory framework on health financing, providers and pricing. A perfect private health care market is not an acceptable "default position".

6. Private Hospitals

According to the Genesis Report (2012), private hospitals account for 36% of health care expenditure (largest portion). Most studies illustrate that private hospitals are responsible for the exorbitant charges in the health care sector (DBSA 2008; Harrison 2009; Mc Intyre and Gilson 2002; Van Den Heever 2000; Wadee 2003). The Econex report (2013:6) explains the expansion of this sector by stating that South Africa had more than 300 private hospitals by 2013. Moreover, it is estimated that 3500 of the nation's clinics are in private hands. (Econex 2013: 6). The research identifies the following four key factors as primary causes of increased costs: the acquisition of beds, expensive technology, concentrated ownership, and commercialisation. We will unpack these crucial factors in the following sections.

6.1 Technology and Bed Acquisition

The Development Bank of South Africa (2008: 27) argues that the costs can be attributed to the increased acquisition of acute beds and expensive technology. For example, the private sector had a bed over-supply of 10 000 by 2008, as a result of adding 4 000 beds between 2004 and 2008 (DBSA 2008:27). According to Econex (2013:6), these hospitals currently own 35 000 beds; whilst providing health services to only 16 % of the population.

We will show how the existence of perverse incentives within the private healthcare sector explains the large amount of funds spent on specialist and private facilities since the 1990's.

The rise in the usage of advanced diagnostic technology has also caused prices to increase (DBSA 2008; Mc Intyre and Thiede 2005). This expansion of sophisticated technology is not driven by the need to provide better health services. It is rather motivated by the fee-for-service principle, which drives private facilities to concentrate on health services that generate the most revenue.

The Council for Medical Schemes (CMS) 2013 report reflects that the highest medical scheme payments in 2012 were:

Speciality	**Payments**
Pathologists	R 5.12 bn
Radiologists	R 4.27 bn
Anaesthetists	R 2.06 bn

Mc Intyre and Thiede (2005:42) provide a succinct explanation of this trend by stating that: "***When expensive high-technology equipment is purchased by owners of private hospitals, substantial pressure is applied on clinicians to use this equipment to earn revenue for the hospital"***.

More worryingly, some doctors support this practice because it provides them with massive financial gains. This specifically applies to those practitioners— especially specialists—who have free or low-cost consulting rooms in private hospitals. These specialists only receive financial benefits associated with share ownership if they promote the increased usage of this technology (Mc Intyre and Thiede 2005:42). This also explains the over-supply of services discussed in earlier sections.

6.2 Concentrated Ownership

The private sector went through a period of growth followed by a consolidation through mergers. The Netcare group has a market capitalisation of US$40 million upon listing on the Johannesburg Stock Exchange (JSE) in 1998 and this had grown to US$3.5 billion by the end of 2006, for a compound annual growth rate of 30%.

Private hospitals are concentrated in 3 main groups, namely Netcare, Medi Clinic and Life Healthcare. Almost 80% of the private hospital market in South Africa is dominated by the three firms.

Hospital Group	**2013 market share**
Netcare	26 0%
Life healthcare	22.2 %
Medi-Clinic	25 %

Van Den Heever (2000: 10-11) argues that this level of concentration has been one of the primary causes of price escalation. Medical schemes have been denied the right to "selective contracting" which could possibly decrease costs (2000:11). The market power of these three groups has been enhanced by the Competition Competition's decision of 2004. It ruled that Medical Schemes could not bargain for prices collectively.

The expansion process of all 3 hospital groups has occurred largely through mergers with smaller hospital groups which has been approved by the Competition Tribunal and resulted in increased concentration in an already concentrated hospital market. This is accompanied by decentralised bargaining between funders and providers resulting in hospitals yielding market power.

COSATU has long raised the impact of the patterns of ownership, how they influence investment trends, production and administration, and how the character of ownership influences pricing by increasing their bargaining powers. According to the CMS, hospital groups are now in a position to dictate prices to medical aid schemes, which are becoming less and less willing to cover the inflated amounts. This power of the private hospitals group results in a pricing regime with stark difference between the tariffs charged by the healthcare providers and the rates the medical schemes are prepared to pay, leaving a greater gap to co-payments by users leading to catastrophic health expenditure even for users who have been able to afford medical aid cover.

This market dominance is particularly pertinent in the cases of Netcare, which is the third-largest hospital group in the world, and the largest in South Africa with annual revenues in excess of R14 billion, employing more than 24,000 personnel, and Discovery Health which in March 2013 had 2.5 million members and nearly 50% of the open medical scheme market. The National Health Service in Britain has indicated that Netcare is their largest private hospital provider of services.

6.3 Profits before access to Health

The super profits of these hospitals is well publicised in the financial press. On 14 June 2013, the Mail and Guardian reported that despite rising input costs, all three posted significant profit increases in their most recent financial statements.

Hospital group	% profit increase
Netcare	7.9 %
Life healthcare	12.7 %
Medi-Clinic	15 %

The Genesis Analytics report (2012) found that profitability had increased dramatically for the hospital groups in the years after they consolidated.

It documented an analysis of the return on capital employed (ROCE) in the South African operations of Mediclinic and Netcare — the two largest groups. It analysed ROCE before and after 2001, which was the year the first merger was approved. Between 1988 and 2001, Mediclinic's average ROCE was 14%. Between 2002 and 2011, ROCE had increased to 23%. Return on capital for Netcare averaged 15% between 1997 and 2001. Between 2002 and 2011, that number had jumped to 22%.

In contrast, in 2013 / 14 the average percentage increase of the wages of workers was 7%.

In the past 5 years, share at these three large healthcare groups have seen substantial gains. (Mail and Guardian:2013)

Hospital group	% shares increase
Netcare	203 %

Life healthcare	158 %
Medi-Clinic	275 %

Economics consultancy Econex (2013) shows that the increase in spending on private hospitals was more than double the rate of headline inflation between 2000 and 2010. Over the decade, the consumer price index (CPI) was 6%. Over the same period, hospital price inflation was 8.5%. Spending on private hospitals increased by 12.2% - double that of inflation, and more than 40% higher than hospital inflation rates.

Between 1992 and 2008, the spending per beneficiary in private hospitals has risen from R1 000 per year to more than R3 000 per year. (CMS:2013)

The 2013 CMS report indicates that total hospital expenditure (which includes ward fees, theatre fees, consumables, medicines and per diem arrangements) consumed R39.4 billion or 35.35% of the R112.5 billion that medical schemes paid to all health care providers. This is an increase of 4.9% on 2012 and represents an increase of 3.1% on pbpa on 2012 – from R4 367 to R4503.90.

This must be seen against the differential between costs in the public and private sectors. The Minister has given graphic examples of the price differential for circumcisions – R400 in the public sector compared to between R6000 and R15000 in the private sector. Innovative Medicines South Africa found on average that private hospital costs were 1438 times more expensive than public hospital costs.

The Genesis Analysis report (2012), referred to earlier, quoted economic theorists Peter Davis and Eliana Garcés, suggests that "a market with few firms … may be one where firms can exercise market power through high mark-ups".

The Genesis research (2012) went on to find that the average return on sales for all three South African hospital groups significantly outstripped those of their global comparators, in some cases by as much as 50%.

Suppliers of medical goods supply these to different players at different prices. Discounts offered may take the form of kickbacks and incentives and can be disguised – sometimes as "marketing fees". The relationship between pharmaceutical companies and doctors / private hospitals needs investigation as behaviours that could be anti-competitive.

7. Private specialists

Private specialists account for 22.86% of health care expenditure. (Genesis:2012). This is broken down as follows:

Speciality	**% share**
Medical specialists	11.39 %
Clinical specialists	10.76 %
Dental specialists	.71 %

A crude estimation of the amount of money paid to specialists a year may be illustrated in the following example. There are approximately 4 000 specialists in South Africa. In 2010 medical schemes alone paid approximately R17 billion to specialists (an average of R4.2

million per specialist), and this excludes users who pay out of pocket or costs additional to medical aid payments for which users are responsible.

These statistics require particular attention as between 1992 and 2008, costs per beneficiary have risen from R1 000 per year to just below R2 000 per year.

The 2013 CMS report indicates that payment to medical specialists amounted to R25.5 billion comprising 24.5% of total health care benefits paid in 2013. This is an increase of 14.6% on 2012.

The high percentage spent on specialists raises the question of over servicing by specialists. It is also indicative of the lack of attention given to the Primary Health Care Approach by the private health sector. An indication of this is that General Practitioners account for only 10% of health care expenditure.

The solution lies with the progressive realisation of better preventative strategies, for example, by employing benefits for vaccinations, screenings, healthcare assessments, contraception, circumcision and so on, as a way to better manage quality health outcomes. This would ultimately result in lower medical aid premiums, and not the consistent and continuing increases year on year.

With the dominance of the three major hospital groups and the relationship which exists between these hospital and the private specialists who use their facilities and services, a number of questions arise:

- How hospital prices are set, i.e. what methods are used in the price setting exercise?
- What is the relationship between the private hospitals and the specialists who use their facilities?
- What incentives are provided for specialists to work at specific hospitals?
- How does this influence the cost and demand for their services?
- Do users choose specialists or hospitals?

8. Medical Aid Schemes

Medical schemes are equally culpable of price inequality in healthcare. One would trust that this is investigated by the Competition Tribunal - the very institution that outlawed collective bargaining in healthcare. The repercussion of this ruling against price setting through collective bargaining has been an exponential increase in health costs since 2003, particularly by private hospitals and specialists as we have indicated previously in this submission.

Medical schemes employ intervention strategies to manage the risk pool better, largely through co-payments and benefit risk strategies through managed care. But we must recognise that the solution does not simply rest with benefit cutbacks and, certainly not, with co-payments as these deal a double blow to members.

Lower income medical schemes members pay a larger percentage of their income in medical scheme contributions than higher income members. This is because a flat rate (or fixed Rand value) contribution is charged by medical schemes rather than an income-related contribution.

The right to health care can be compromised by the requirement of large co-payments, and is exacerbated by high monthly payments for medical schemes which do not sustain the health needs of the user for much of the year. This begs the questions of whether these high co-payments are necessary to sustain the survival of the specialists / hospitals and whether they contribute to the high levels of profit which range between 15% and 25 % for private hospitals. It begs further questions - whether these large co-payments have resulted in undesirable business practices between medical aids and hospitals, and medical aids and pharmacies with which they select to work.

Medical schemes administrators generate large administrative costs (up to 23%) that, along with profits, divert resources from clinical care to the demands of business. Based on the 2013 CMS Annual Report approximately R100 per average beneficiary per month was spent on administration costs amounting to approximately R700 million per month and approximately R8.5 billion per annum. This is largely carved out between the top three administrators in South Africa – whom account for over 80% of all medical scheme administration, Discovery, Metropolitan Health (MMI) and MEDSCHEME

A further cost which is borne by medical aid members is the "stipends" which trustees pay themselves. The CMS reports that in 2013 the total costs of payments to trustees of the top 6 medical schemes was R25 021 000, with the highest cost of this made by GEMS, the public sector schemes amounting to R795 100, an average per trustee being R568 000. Bonitas, Fedhealth, Hosmed and Discovery pay trustees on average R 3 600 000 per year.

As in the private hospital sector, the medical aid sector has become more concentrated and is now largely carved out between the top three administrators in South Africa –Discovery, Metropolitan Health (MMI) and MEDSCHEME. They account for over 80% of all medical scheme administration. The largest, Discovery, is now the most expensive on a per beneficiary basis. This concentration has occurred through takeovers of smaller closed medical schemes, and in the words of Noam Chomsky quoted at he beginning of this submission makes *"people feel they are helpless, that the only role they can have is to ratify decisions and to consume".*

The expansion of the private sector has also increased medical aid costs. As illustrated earlier, expenditure in this sector has been characterised by an excessive increase in the number of beds, and the rapid introduction of expensive technology. It should be noted that this is also caused by anti-developmental regulation by the state. Provincial health administrators abuse the licensing system allowing private hospitals to acquire more beds and expensive technology. There is a correlation between increased medical aid costs and these two trends. The DBSA (2008:27) report explains that these capital costs are shifted to medical schemes, who then charge their members more.

The increased medical aid costs are also linked to the over-financialisation of the South African economy. According to Khan (2012:570-580), this term refers to the dominance of a privately-owned financial sector in the economy. It directs all financial activity towards profit making, speculation and quick returns on investments. In other words, the character of private health care funding cannot be separated from the investment and expenditure patterns observed in the general financial architecture of the country. The logical conclusion of this observation is that the nation cannot achieve equal access to health care if finance is dominated by the private sector. Finance in the private sector is not guided by the goals of social equity and increased access to essential services such as health.

There have been two suggestions from a number of quarters – mainly those who benefit from the current pricing of the private healthcare industry:

1. Mandatory membership of a medical scheme by employed people.
2. The establishment of a risk equalisation Fund.

We would be opposed to both these interventions as they would be contrary to the efforts to introduce an NHI which, as we have observed earlier in this document, is currently the stated policy of the 5th administration of government as enshrined in the elections manifesto of the ANC

9. Conclusion

There is ample evidence which proves that private health care prices in South Africa are too high. We have a runaway private health provider sector, which is responsible for huge inequalities in healthcare provision. According to the Standard Bank, in February 2014, CPI inflation was 5.9% (Year on Year) (Y/Y), medical insurance inflation was 9.3% (Y/Y), while medical industry inflation was 8.6% (Y/Y). This unequal, contradictory and intersecting relationship continues to undermine affordable health care provision.

We question whether competition - which is at the centre of this inquiry - can accommodate making recommendations on appropriate policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality private health care" as their terms of reference suggest. Our concern is that the structure of the private health care market must not interfere with the constitutional right of South African people to access health care.

Whilst the inquiry may yield desirable outcomes for regulating the private sector with possible short term benefits for the general public, there are inherent dangers in the form of unintended consequences, such as the further entrenchment of market principles in healthcare and the creation of a private sector bias in terms of the determination of costs which, in fact, presently resides under the National Health Act and falls under the jurisdiction of the Minister of Health.

The CC report must assess the issues which we have raised in our report and ensure that these do not negatively influence the impact on the cost of health care for the people in South Africa.

COSATU firmly believes that the solution to "the artificially high private health care costs" is the full implementation of the NHI together with a coherent tariff regime set by the Minister of Health, and administered through a publicly administered single payer / single purchaser fund.

However, in the interim, we submit that the regulation of the private health industry through the re-instatement of a NHRPL is an urgent priority.

This COSATU submission was prepared by the following unions:

South African Municipal Workers' Union
National Education Health and Allied Workers' Union
Democratic Nursing Organisation of South Africa
South African Democratic Nursing Union
South African Medical Association

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