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SECTION27 SUBMISSION ON

THE DRAFT STATEMENT OF ISSUES

FOR THE MARKET INQUIRY INTO THE PRIVATE HEALTH CARE SECTOR

30 June 2014

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Introduction

1. SECTION27 is a public interest law centre that seeks to influence and use the law to protect, promote and advance human rights. One of our priority areas is the right of access to health care services as guaranteed by section 27 of the Constitution. As an organisation that acts in the public interest, we are concerned about pricing and the drivers of the high cost of health care in the South African private health care sector.

2. Access to health care services is enshrined in the Constitution of South Africa as a fundamental human right. Section 27(2) imposes an obligation on the state to take reasonable legislative and other measures to achieve the progressive realisation of this right. As both the Terms of Reference and the Draft Statement of Issues acknowledge, private health care provision takes place within the context of this constitutional commitment to the provision of universal health care services to all people in South Africa. This commitment applies both to those who access health care through the public health care system and the 8.7 million people who do so through the "market" for private health care.

3. We agree that the various explanations put forward for the costs, prices and expenditure increases in the private health care market, a market inquiry is an appropriate mechanism to establish the facts upon which the Panel can make evidence-based recommendations that serve to promote competition that is grounded in enhancing affordable, accessible, innovative and good quality private health care in South Africa. We commit to supporting the Commission in conducting a thorough, transparent, participatory, patient-focussed inquiry.

4. We make this submission in response to the Competition Commission's call for public comment on the Draft Statement of Issues for the market inquiry into the private health sector. We first make some general comments on the important principles that should be at the centre of all of the Market Inquiry Panel's (Panel) work and then make detailed comments on the content of the Draft Statement of Issues. Throughout, our intention is to assist the panel in developing a patient and user focussed approach to both the substance

and the process of the inquiry, which places the right to health care at the centre of its investigations and competition law analysis.

A rights and patient-focussed inquiry

The relevance of the right to have access to health care services

5. The right to access health care services places a responsibility on the state to regulate the private health care sector so as to ensure that it is affordable and accessible. The Constitutional Court held in *New Clicks* that "[g]overnment is entitled to adopt, as part of its policy to provide access to health care, measures designed to make medicines more affordable than they presently are".[1] This is part of the state's duty to take reasonable and other measures to progressively realise the right to health. This obligation must be fulfilled "diligently and without delay".[2] We submit that the same is clearly of application to health care services more broadly. Moreover, the state's obligation to respect, protect, promote and fulfil the right to health care services extends to all state institutions,[3] including the various regulators within the private health care sector, and crucially the Competition Commission itself and the Panel. We submit that in the context of the market inquiry, both the Panel and the Commission are required to interpret their mandate and powers in terms of the Competition Act and Terms of Reference in light of the spirit, purport and objects of the Bill of Rights and most particularly the right to access health care services.[4]

6. A rights-focussed approach may require state intervention in markets through appropriate regulation. The importance of a rights conscious approach to the heath care, has already proven its value in the Treatment Action Campaign's court-assisted attempts to resolve "market failures" in the private sector which rendered live-saving antiretrovirials inaccessible to those in need:

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[1] *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others* (CCT 59/2004) [2005] ZACC 14; 2006 (8) BCLR 872 (CC); 2006 (2) SA 311 (CC) (30 September 2005) at para 32.
[2] Constitution, s 237.
[3] Constitution, s7(2).
[4] Constitution s 39(2).

> "As we know, the drugs used to treat HIV are manufactured by private companies and sold at prices far in excess of the purchasing power of those who need them most. Where the law places obligations on the state to promote treatment and prevent transmission, the law is operating to help prevent millions of people infected with HIV from becoming victims of – to use an economics term – 'market failure'."[5]

7. In addition to the consistent acknowledgement of the state's obligations in terms of the right to health care it is crucial that the Panel confront the constitutional obligations placed directly on participants in the market inquiry by the Constitution.[6] Though the nature and extent of constitutional obligations that participants in the market carry will vary, they at very least bear a "negative constitutional obligation not to impair" patients' rights to health care services.[7]

8. We submit that, although the extent of obligations that the Constitution places on the "natural and juristic persons" may vary,[8] the nature and content of the right to health care lends to strong support to scrupulous application to participants in the market for private health care. Participants in this market historically chose and continue to choose to operate for profit in the market for health care. In addition to strong ethical and moral obligations, participants have indirect (through government regulation) and direct constitutional obligations (through section 8(2) of the Constitution). The healthcare products and services which market participants trade in fall squarely within the government's constitutional mandate to progressively realise the right to access health care services.

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[5] Chief Justice Sandile Ngcobo, *Address by the Chief Justice, at the fifth South Africa HIV and Aids conference*, Durban (07/06/2011) available at http://www.polity.org.za/article/sa-ngcobo-address-by-the-chief-justice-at-the-fifth-south-africa-hiv-and-aids-conference-durban-07062011-2011-06-07, accessed on 30 June 2014.

[6] Constitution s 8(2).

[7] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* (CCT 29/10) [2011] ZACC 13; 2011 (8) BCLR 761 (CC) (11 April 2011) at para 54-65.

[8] According to s 8(2): "A provision of the Bill of Rights binds a natural or juristic person *if, and to the extent that, it is applicable taking into account the nature of the right and the nature of any duty imposed by the right*."

9. When individuals and private companies select to trade in markets in which the products and services they provide are constitutional rights, we submit that they take on both: 1) a business environment which, in a constitutional democracy with entrenched socio-economic rights, will be strictly monitored and appropriately regulated; and 2) significant direct constitutional obligations of their own. While it is a legitimate policy choice for the government to allow this commercial activity, as we have argued it retains a constitutional obligation to regulate this market, precisely because the market determines health outcomes and therefore access to the right to health care services of 17% of South Africa. We therefore encourage the Inquiry Panel in the strongest terms to grapple with both the state and market participants constitutional obligations throughout its investigations.

The relevance of other rights in the Bill of Rights: dignity, equality and life

10. The Constitutional Court has repeatedly stated that the rights in Bill of Rights do not operate in artificially constructed ideological silos. They intersect, interact and inform one another.[9] In the particular context of socio-economic rights, the Court has indicated that the Constitution requires that "everyone must be treated with care and concern".[10] The animating values of the Constitution including human dignity which is the "fountain of all rights" and *ubuntu* which "runs like a golden thread"[11] through the Constitution and is

[9] *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1999 (1) SA 6; 1998 at para 112 ("I will deal first with the question of inappropriate separation of rights and sequential ordering, that is, with the assumption that in a case like the present, rights have to be compartmentalised and then ranked in descending order of value. The fact is that both from the point of view of the persons affected, as well as from that of society as a whole, equality and privacy cannot be separated, because they are both violated simultaneously by anti-sodomy laws. In the present matter, such laws deny equal respect for difference, which lies at the heart of equality, and become the basis for the invasion of privacy. At the same time, the negation by the state of different forms of intimate personal behaviour becomes the foundation for the repudiation of equality. Human rights are better approached and defended in an integrated rather than a disparate fashion. The rights must fit the people, not the people the rights. This requires looking at rights and their violations from a persons-centred rather than a formula-based position, and analysing them contextually rather than abstractly").

[10] *Government of the Republic of South Africa and Others v Grootboom and Others* (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000) at para 44.

[11] *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995) at 306.

applicable to state institutions and private parties alike[12] require "group solidarity, compassion and respect".[13]

11. In the context of the right to access health care services, it is crucial that the Panel keep the dignity of users of the system at the core of its focus. The nature of health care markets often makes them difficult for users, lacking expertise, to comprehend. Lengthy standard term contracts, drafted by teams of lawyers also deepen the power imbalances caused by information asymmetries between users, health care provides and medical schemes. These contracts, particularly when it comes to the crucial and emotionally fraught decision of what to do with one's own and one's family's health, present serious challenges to self-autonomy, "which is the very essence of freedom and a vital part of dignity."[14] These concerns are all the more relevant when these decisions are about one's health, and life threatening and emergency situations. This has resulted in the Constitutional Court emphasising the strong connection between the rights to life and dignity:[15]

> "Other rights may be limited, and may even be withdrawn and then granted again, but their ultimate limit is to be found in the preservation of the twin rights of life and dignity. These twin rights are the essential content of all rights under the Constitution. Take them away, and all other rights cease."[16]

12. Finally, the Panel should bear in mind the deeply unequal nature of our society in general and the division between the public and private health care systems in particular, in the context of the right to "equal protection and benefit of law" and our Constitution's

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[12] *Everfresh Market Virginia (Pty) Ltd v Shoprite Checkers (Pty) Ltd* (CCT 105/10) [2011] ZACC 30; 2012 (1) SA 256 (CC); 2012 (3) BCLR 219 (CC) (17 November 2011) at 23-4 and 71.
[13] *S v Makwanyane* at 307.
[14] *Barkhuizen v Napier* (CCT72/05) [2007] ZACC 5; 2007 (5) SA 323 (CC); 2007 (7) BCLR 691 (CC) (4 April 2007) at para 57.
[15] *Soobramoney v Minister of Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) ("The state undoubtedly has a strong interest in protecting and preserving the life and health of its citizens and to that end must do all in its power to protect and preserve life.").
[16] *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995) at para 84.

entrenchment of the "*achievement* of equality" as a founding value.[17] The Constitutional Court itself has acknowledged that access to equal quality health care is often dependant on access to wealth.[18] Indeed, dignity and equality are themselves inseparably linked,[19] and, the Court, as users of the healthcare system are painfully aware that "equality delayed is equality denied."[20]

13. We therefore submit the rights to health care, equality, dignity and life are interconnected and interdependent and should be grappled with constantly by the Panel in its analysis.

What is the practical relevance of this rights analysis to the Panel?

14. Although the state's constitutional obligations are listed as a primary rationale for the inquiry in the Terms of Reference, we are concerned that the both Terms of Reference and The Draft Statement of Issues do no more than merely state the relevance of the right to have access to health care services. We submit that the Statement of Issues should acknowledge that the rights to access to health care, and the related rights to dignity, life and equality, are the core rationale for the inquiry, not merely as part of its context, and explicitly clarify that these rights are relevant in the following respects:

- In understanding the state's obligation to regulate the private health care sector;
- In understanding the obligations of participants in the private health care sector;
- In interpreting the Competition Act, the Terms of Reference of the Inquiry and other guidelines and statements it produces. In particular in interpreting the public interest and equity-based aims of the Act; and

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[17] Constitution, s 1, 9.
[18] *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at paras 17 ("The crux of the problem, however, lies elsewhere: what is to happen to those mothers and their babies who cannot afford access to private health care and do not have access to the research and training sites?") and 79 ("Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means").
[19] *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* (CCT11/98) [1998] ZACC 15; 1999 (1) SA 6; 1998 (12) BCLR 1517 (9 October 1998) at para 120.
[20] *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism and Others* (CCT 27/03) [2004] ZACC 15; 2004 (4) SA 490 (CC); 2004 (7) BCLR 687 (CC) (12 March 2004) at para 74 per Ngcobo J.

- In ensuring that its understanding of the importance of competition in the health care market is informed by the fact that in this market, competition analysis should be focussed at producing better health outcomes.

The importance of an expansive understanding of competition law

15. We note that, as has been acknowledged by the Constitutional Court, the Competition Act "deliberately sets out both equity and efficiency-based goals".[21] These purposes are broad and include advancing "the social and economic welfare of South Africans".[22] The purposes of the Act must be understood in both the historical and contemporary contexts of the South African economy, and in the context of an inquiry into the private health care sector through the lens of the right to access health care services. In this regard, we encourage the Panel to follow the approach of the Competition Tribunal in *Competition Commission of South Africa v Sasol Chemical Industries Limited*, which, in coming to the conclusion that Sasol had engaged in excessive pricing in contravention of the Competition Act considered the "particular and very significant historical state support" and the absence of "risk taking and innovation" on Sasol as relevant to assessing its position of dominance.[23] The nature of Sasol's advantage was found to be not only monetary, but in "creating" Sasol's dominance which "has endured in the current market(s)".[24]

16. From its conception, the Competition Act was intended to be a "key instrument under democracy to address corporate power", in "addressing the apartheid legacy" and to "correct market *outcomes*". Competition law in South Africa is therefore conceived of as "part of an economic reform process" aimed at restructuring inequitable and inefficient markets which developed under apartheid.[25] Competition law is not outcome neutral, the balance of equity and efficiency-based considerations must be weighed up with quality

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[21] *Competition Commission v Yara South Africa (Pty) Ltd and Others* 2012 (9) BCLR 923 (CC) at 49.
[22] Section 2(c) of the Competition Act.
[23] *Competition Commission vs Sasol Chemical Industries Ltd and Safripol (Pty) Ltd* Case No: 011502, (executive summary available at http://www.comptrib.co.za/cases/complaint/retrieve_case/1722 accessed on 30 June 2014 at para 89 and 119).
[24] Id at para 108.
[25] Makhaya, G and Roberts, S *Expectations and Outcomes; Considering Competition and Corporate Power in South Africa Under Democracy* (2013), *African Review of Political Economy* Vol 40 No 138 556.

health outcomes as a priority given that constitutional rights are implicated. This is why the National Health Act aims to address the "injustices, imbalances and inequities of health services of the past"[26] which were "generated by apartheid".[27] The Panel's analysis of and recommendations for the various markets that form the private healthcare sector should therefore consider the historical context of these markets.

17. The Commission's mandate in contributing towards restructuring the economy is particularly relevant with regard to its power to initiate market inquiries. Though the Constitutional Court has described the Commission as "the lifeblood of the Act",[28] the majority of the Commission's powers do not allow it a broad scope to contribute towards the restructuring of markets. The power to initiate market inquiries is different. This power, uniquely amongst the Commission's powers, allows it to proactively scrutinise markets in order to "achieve the purposes of the Act" and provide regulators, lawmakers and policymakers with direct recommendations. In the context of the private health care market, these powers therefore provide the Commission with the ability to contribute towards both the achievement of better health outcomes and the restructuring of the economy.

18. We therefore encourage the Panel to avoid a narrow purely efficiency-focussed perspective of competition analysis and competition law. We encourage the Panel to embrace its crucial public interest role in contributing towards the realisation of the right to have access to health care services and interrogating whether its recommendations may contribute towards the creation of equitable markets for private health care which advance the social and economic welfare of all South Africans. Nevertheless, the Panel is correct to acknowledge that competition law, even broadly construed, is not a panacea for all the challenges in the health care system which require reform. While we encourage the Panel to adopt an expansive understanding of competition law, the Panel should also

[26] National Health Act 61 of 2003, Preamble.
[27] Hassim et al, *Health and Democracy: A Guide to Human Rights, Health Law and Health Policy in Post-Apartheid South Africa* (2007) at 167.
[28] *Competition Commission v Yara South Africa (Pty) Ltd and Others* (CCT 81/11) [2012] ZACC 14; 2012 (9) BCLR 923 (CC) (26 June 2012) at 49.

remain cognisant of the limitations of competition law and the need for complementary reform through other mechanisms.

The Breadth and Generality of the Draft Statement of Issues

19. Given the complexity of the private health care system, we are concerned that the Draft Statement of Issues has been too broadly phrased and find that it lacks the necessary clarity, focus and detail on how the Panel plans to undertake its investigation into the private health care market and what the Panel plans to focus on.

20. In this regard, the Draft Statement of Issues would benefit strategically from a systematic analysis of how the market under inquiry has been determined, identifying the characteristics of the way that privately-funded health care services in South Africa operate and that appear to be particularly relevant when assessing competition in the sector. Identification of these characteristics should inform the formulation of the Draft Statement of Issues in general and theories of harm in particular. Spelling them out would help frame the market inquiry.

21. In our view, reference to the preliminary research that has informed the Terms of Reference as well as research and analysis that has since been conducted on the identification of the relevant markets should also form part of the Draft Statement of Issues. Although the Panel acknowledges that it does not begin the process with the opinions of the Commission expressed in the Terms of Reference, its power to investigate is bound by the Terms of Reference. The Draft Statement of Issues should be reconciled with the Terms of Reference. This would allow for greater clarity for participants and a better understanding of the panel's vision for the execution of its powers during the course of the inquiry. An assessment of the nature and form of competition in the market are critical and, again, should form part of the Draft Statement of Issues. This would make the process more transparent and would also contribute to greater stakeholder understanding of the processes that the Panel and the Commission have adopted.

Assessing competition

The over breadth of the theories of harm

22. We welcome the inclusion of the theories of harm as a practice tool in competition analysis and as an approach to guide the market inquiry into the private health care sector. Our understanding of the theories of harm is that they are hypotheses of how distortions might arise in a market and how they adversely affect people accessing the market. Further, the theories of harm refer to how certain market dynamics can interact to prevent competition within the sector. This in turn may have an adverse effect on prices, quality of care, and users' access to affordable private health care.

23. We understand that at this early stage of the inquiry the theories of harm may be set out in broad, generic terms. It is also our understanding that as the Panel will investigate the operation of competition within the private health care market it will review its theories, making them increasingly specific to the investigation.

24. We are concerned however, that the theories of harm as a practice tool in a market inquiry competition analysis of the health market may not sufficiently address the issue of public interest and the nature of private health care provision within the constitutional framework informing the right of access to health care.

25. In addition, the theories of harm have been left exceptionally wide. Given the huge task at hand and limited time frames, there is a need, even at this early stage for greater, more precise engagement with this side of the investigation. In this regard the Commission might wish to have regard to the approach taken by the UK Competition Commission (UKCC) in establishing the 'theories of harm' during its recently concluded private health care market investigation. The UKCC set out more detailed and specific theories of harm with a much more narrow scope.

The under-inclusive interpretation of relevance of public interest provisions

26. In paragraph 55 of the Draft Statement of Issues the Panel discusses the effects arising in relation to each of the theories of harm. The effects mentioned in the Draft Statement of Issues are:

"higher costs, higher prices (including premiums), impaired access, as well as less innovation, and lower quality of service. In addition, "*public interest issues affecting employment, small and medium-sized enterprises and the spread of ownership in the economy could arise*."

27. We agree that the scope of the inquiry will have an impact on employment, small and medium-sized businesses and the spread of ownership within the economy. However, we refer the Panel to our detailed submissions above on the public interest provisions of the Act and their relevance to the Panel's work. It appears that the Panel has unnecessarily limited the potential relevance of public interest analysis in the context of theories of harm to only some of the purposes listed in the Act, and more particularly those usually associated with merger analysis.[29] We submit that the public interest purposes of the Act are sufficiently broad to incorporate, amongst other factors, social welfare issues, most crucially the importance of ensuring quality health outcomes for users of the private health care market. We encourage the panel to take an expanded view of the approach and the scope and influence of the Act's public interest provisions in the context of theories of harm and its interpretation of the rest of the Act.[30]

[29] Section 2 of the Competition Act reads:
Section 12A(3) of the Competition Act reads:

[30] The public interest provisions emanate most clearly from the purposes of the Act. The Constitutional Court has frequently favoured a purposive interpretation of legislation, which takes into account in particular the explicitly stated purposes of the Act. The broad public interest purposes of the Act are therefore relevant in the interpretation of each and every provision of the Act.

Panel's Criteria for Prioritising Work

28. We agree with the breadth and importance of the criteria the panel has set for the prioritisation of its work. We emphasise that these priorities are crucially geared towards the improvement of health outcomes for users of the private health care system. This is, in our view, on a purposive, contextual, interpretation of the Competition Act, not only an appropriate explicit focus for the Panel but one which is constitutionally required.

Consumers

Access to information

29. Asymmetric information, in contrast to perfect information, is a defining characteristic of markets for health care which are marked by an unequal level of information between the different participants, mainly between a doctor and her patient. The problem of asymmetric information raises a string of competition concerns in other countries. We agree with the Panel that the ability of patients to make optimal decisions is affected by an accurate assessment of their health care needs, the quality of information at their disposal, and the incentives and actions of the various actors with whom they interact, mainly health care service providers and funders. Health care users' knowledge of how the market for health care works and the choices available to them are at the core of the exercise of their right of access to health care services.

30. We suggest that the Panel does not limit its focus on the kind of information that is available to users of the health care system, but also whether the information is provided in a manner that all users can understand.

Medical schemes, service providers, patients

31. The Panel will explore the nature of competition among medical schemes and other providers of health insurance. In this context, the Panel should not overlook the nature of

competition among administrators and the impact this has on the affordability of medical scheme coverage as well as range of products available to the public for purchase.

32. We agree with the Panel that it is important to understand what influences decisions made by and/or on behalf of patients and to understand the extent to which the interests of patients and the interests of health care providers are aligned with good health care outcomes.

Out of pocket expenditure

33. In paragraph 26 the Draft Statement of Issues makes reference to 'out of pocket expenditure' and 'co-payments'. Whereas the Medical Schemes Act provides for out of pocket expenditure, the Panel may wish to look into how and where legislation allows for out of pocket expenditure, and the circumstances in which patients are placed at financial risk despite medical scheme coverage. The Panel should also consider looking into areas where there has been an erosion of covered benefits whilst medical scheme premiums have risen, leading to an overall decrease in insurance coverage, despite rising private expenditure on health care.

Financing of Health care Services

34. We welcome that the Panel will investigate the relationship between medical schemes and medical scheme administrators and its impact on competition. We are specifically concerned about the lack of transparency on the side of administrators regarding the setting of benefits, in particular the decision on formularies and risk sharing arrangements. In light of the considerable proportion of total medical scheme expenditure that administrators account for, we are concerned about the relationship between schemes and administrators given that one is intended to be non-profit and the other is a for-profit model. An examination of the corporate structures of medical schemes and administrators and the overlaps are key in this regard.

35. We further welcome an investigation into cost management mechanisms and hope that the Panel will also investigate to what extent cost savings are passed on to the medical scheme members or are being kept as profits at the administrator level.

36. We welcome the focus on brokers and the incentives of brokers and medical schemes administrators and other insurers. In this context, we recommend that the panel consider the inter-relationship between regulated medical schemes and unregulated insurance products.

37. We wish to draw the Panel's attention to the draft regulations published by the National Treasury[31] which propose legislative and regulatory changes on long and short-term insurance products and which we believe are likely to seriously harm the rights-based framework that protects medical scheme beneficiaries and the health system. We are concerned that the proposed reforms create a risk for the stability of Medical Schemes, and therefore health care, and that the public consultation process regarding demarcation between medical schemes and financial products has been insufficient and fails to reflect the substantial public interest and constitutional issues involved. Thus far no substantial analysis has been provided regarding the possible impact on the public interest of the proposed regulations of the proposed regulation of insurance and whether the health care sector should be diversified in such a manner.

Providers of Health Care Health care Products and Services

General Practitioners and Specialists

38. We welcome the focus on GPs given their important role in health care provision, as one of the gatekeepers and primary health care service providers as well as a potentially

[31] Government Notice No 326: Proposed Amendments to Draft Demarcation Regulations Made Under section 72 of the Long-Term Insurance Act, 52 of 1998 published in Government Gazette No 37598 of 29 April 2014; Government Notice 325: Proposed Amendments to Draft Demarcation Regulations Made under Section 70 of the Short-Term Insurance Act, 53 of 1998 published in Government Gazette No 37598 of 29 April 2014.

important mechanism in controlling health care expenditure. We also note their envisaged role in the proposed National Health Insurance policy.

39. GPs have an important role to play in driving demand and directing patients along the health care supply chain, through referrals, further testing, and prescribing medicines. We recommend that the panel investigates to what extent GPs may be under-providing services relative to their skill set and over-referring patients to specialists leading to cost escalation as higher charging specialists treat patients with minor ailments that should have been treated by GPs. We believe GPs should be strengthened in their role as primary care givers. We note that many patients trust their GPs to address their primary health care needs. GPs thus bear significant obligations with regard to breaking down information asymmetries between patients and market participants and ensuring the accessibility and comprehensibly of the health care system and the rights of patients.

40. It is important for the Panel to focus on specialists as they constitute the largest out-of-hospital cost item and are considered a key driver of expenditure increases.[32] According to the most recent Annual Report from the Council for Medical Schemes, medical specialists comprised 23.3% of total health care benefits paid in 2012. We recommend that the Panel focus on a spread of specialists such as pathology, radiology and anaesthetists for several reasons.

41. We recommend that the Panel focus on pathology, radiology and anaesthetists. Pathologists (R5.12bn), radiologists (R4.27bn) and anaesthetists (R2.06bn) were the specialists that were responsible for the highest medical scheme benefits paid in 2012.

42. The Pathology practices are capital intensive, requiring large volumes of tests to be done, over which the costs of equipment can be amortised. The private pathology sector is also highly concentrated. It has been estimated that around 90% of this sector is dominated by three large practices. Lancet has an estimated market share of 26%, Ampath 33%, and Pathcare 25%. This may pose significant competition questions for the Panel.

[32] Terms of Reference.

43. We note the intention of the Panel to review the HPCSA rules that prevent corporate employment of doctors and specialists. Historically the rationale for prohibiting corporate employment of doctors and specialists has been that it compromises professional decisions on patient treatment. This rationale should be re-examined in light of the way the private sector has developed over time. We agree that the Panel should look closely at how these rules impact on the incentives and conduct of health care service providers and should be mindful of the impact that a change of these rules may have on human resources in the public sector.

Pharmaceutical products

44. We support the Commission's approach to pharmaceutical products. The term 'consumables' used in paragraph 43 may however be misleading. While medicines are classified as consumables, other consumables are not regulated in the same way as medicines. Reference to the single exit price, for example, refers only to medicines, and not to other consumable products. It is important to note that medical devices can also be classified as consumables but are not regulated at all. We brought this issue to the attention of the Commission in our submission on the Draft Terms of Reference and the wording has subsequently been corrected in the final Terms of Reference where reference is made to "health care goods" such as medical devices and pharmaceutical products and product manufacturers for medical consumables, medical devices, and medicines. We recommend that this be consistent in the final Statement of Issues.

45. We also think it is important to note that the price of medicines is only partially regulated. The Single Exit Price regulations referred to in the draft Statement of Issues, at present provide guidelines for the annual increase of medicine prices. However the setting of medicine prices for patented and generic medicines occurs in the absence of any regulations. The practice has been that pharmaceutical company responsible for marketing the drug, provide information to the Department of Health. The Pricing Committee appointed by the Minister is responsible for setting the price. The regulations

that are intended to guide the Pricing Committee in making this decision are not yet in place. The draft Benchmarking Methodology regulations were published for comment on 12 May 2014.[33]

46. While generic competition has been shown to place downward pressure on prices in other countries, it is unclear whether it has the effect of reducing prices of medicines within the current regulatory framework. The question of whether the current regulatory framework and draft proposals serve the purpose of reasonably limiting prices should form part of the Panel's assessment of the regulatory framework.

The Regulatory Framework

47. We express particular support for the inclusion of the regulatory framework in the theories of harm. We wish to emphasise the importance of a thorough investigation of the current regulatory framework and how it affects competitive outcomes. In our view, it is of upmost importance for the Panel to look at the numerous regulations that currently govern the health care sector in South Africa and to identify possible deficiencies and unintended consequences in the regulatory framework and how they may distort competition, raise barriers to entry and expansion, and maintain and/or create positions of market power.

48. We urge the Panel to critically review not only existing legislative measures and regulations but the functioning of existing regulatory bodies such as the Council for Medical Schemes (CMS), the Health Professional Council (HPCSA) and the Medicines Control Council (MCC) among others. In particular, an assessment of their existing capacity to fulfill their mandates, including: access to human and financial resources; ability to enforce compliance with their decisions; accessibility to users of the health care system; and political independence.

[33] Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances (Benchmark Methodology) Government Notice No 354 published in Government Gazette 37625.

49. We stress, for example, that regulatory bodies should be easily accessible to users of the health care system and that their processes should be easily understandable, expediently completed and where possible not require access to legal representation.

The Role of the Public Health Care Sector

50. We agree that the public sector is an important factor for the Panel to consider and an understanding of how the public and private health care sectors interact will be invaluable. It is critical that links between the private and public sector are considered when making legislative, regulatory and policy recommendations and that the impact on the country's health outcomes is also considered.

51. Some examples of the interaction between the two sectors:

    51.1. Competition deficiencies that cause high prices which in turn put upward pressure on the tax subsidy on healthcare expenditure, funnelling resources from fiscal resources, which could be available for spending in the public sector. This assumes that increasing expenditure in the public sector would be optimal (i.e. current spending is not already optimal). Tax deductions for medical expenditure represent the largest category of deductions granted to taxpayers (at R61bn[34], representing 46% of all deductions in 2012). Medical aid was also the largest fringe benefit paid by employers, at R38bn[35] in 2012.

    51.2. High prices sometimes lead to patients running out of medical scheme benefits and dumping of patients into the public sector.

    51.3. Providers may shift their time to the private sector to the detriment of the public sector.

52. The Recommendations of the Panel have to be directly related to remedying the identified deficiencies in competition. However, additional requirements can be placed on them,

[34] This amount reflects income not taxed, not the actual loss to the fiscus, which would be a fraction of this amount depending on the tax rates applicable.
[35] SARS and National Treasury (2012), Tax Statistics 2013. Accessed from http://www.sars.gov.za/AllDocs/Documents/Tax%20Stats/TStats%202013%20WEB.pdf on 24 June 2014.

namely that they do not lead to outcomes that constrain the state's ability to meet its obligations, particularly in terms of the constitutional right of access to health care services.

53. Where possible, the interests of the public and private sector in providing health care services and improving health outcomes should be aligned and changes in the private sector should not undermine access to health care services in the public sector. This is particularly relevant in light of the proposed National Health Insurance (NHI) policy, which is aimed at improving access to health care services across the whole of South Africa's health system. The publication of the White Paper on NHI is said to be imminent and the Panel may have an opportunity to engage with the policy paper in the context of the inquiry.

CONCLUSION

54. We wish to thank the Competition Commission for the opportunity to make this submission. Given the importance of the issue we are open to further engagement with the Competition Commission and the Panel to providing further comment in order to support the process in any way we can to best serve the public interest.

55. The following have endorsed this subssion:

55.1 Treatment Action Campaign

55.2 Budget Expenditure and Monitoring Forum (BEMF)

55.3 National Consumer Forum (trading as Consumer Fair)

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