SPEAKING NOTES FOR THE MINISTER
PRIVATE HEALTHCARE COSTS

One of the key challenges for the Department of Health since 1994, has been access and affordability to healthcare. We inherited a healthcare system that was segregated along racial and economic lines. The public health s was under resourced and segregated while the private health sector was accessible to only 20% of the population. Our policy interventions since 1994 have been focussed on the provision of accessible, affordable, quality healthcare for all South Africans.

One of our very early challenges was improving access to affordable medicines. We introduced a range of interventions to address these challenges.. These interventions include provision for parallel importation of medicines, essential medicines policy, generic substitution policy, expedited registration for essential medicines, single exit price for medicines, logistics fees, dispensing fees, international benchmarking, reference pricing and pharmacoeconomic assessments. These policies have been held up as a gold standard for other developing nations.

The medicine pricing regulations have been most successful in this regard. Since the introduction of the regulations there has seen in excess of 20% reduction in medicine prices. This has resulted in a savings of over R2.3 billion on medicines. What is most encouraging is that the decline in medicine prices is linked to a proportional increase in utilisation of medicines. It is clear that medicine prices were out of reach of most South African s the prices decline more South Africans are accessing these medicin

Our success in regulating medicine prices has attracted much interest from a number of developing countries that would like to achieve similar results. Infact the World Health Organisation has requested that we consider writing a handbook on the effective regulation of medicine prices given that access to

affordable medicines remains a serious challenge in most developing countries.

While I have highlighted some of our success in creating greater access to affordable medicines, we also face significant challenges. The reductions in medicine prices did not result in overall healthcare savings for the patient. This has been largely due to increases in the tariffs of private hospitals, specialists and medical scheme administration.

Since 1999 we have seen significant increases in private hospital expenditure and specialist fees. Prior to 1999 the ownership of private hospitals was largely in the hands of independents with no dominant market player. After 2000 we have seen consolidation in private hospital ownership with three large groups. These groups own over 80% of the private beds in the country and one group is dominating in each of the regions.

This market dominance together with the Competition Commission ruling against collective price negotiation weakened the bargaining power of medical schemes. Consequently private hospital price increases have out stripped inflation. In 1997 medical schemes paid R803 per beneficiary for hospital benefits. In 2005 this increased to R2320 per beneficiary for hospital benefits. This is clearly an unsustainable situation that would lead to the demise of the sector.

Specialist costs have also been increasing at a rate that exceeds inflation. Specialists derive a significant portion of their income from hospitalisation so it is not surprising specialist costs have followed a similar trend to hospital costs.

In 2007 we legislated the National Health Reference Price List (NHRPL) which provides a transparent basis for the determination of the true costs of goods and services in the private sector. We anticipate that the National Health Reference Price List would contribute to lowering costs in the private sector.

In September 2007 I convened a Private Healthcare Sector Indaba to discuss my concerns about the unaffordabaly high costs in this sector. At this Indaba everyone agreed that all was not well in the private healthcare sector and that government would indeed have to take regulatory measures to ensure that the sector was sustainable.

A few months later we hear that the private hospital groups were raising their tariffs with effect from 1 January 2008. Even more disturbing was the rate of increases (8-33%) that was reported. Despite the high costs of private health care and decreasing affordability of medical scheme membership, healthcare providers and schemes continue to implement price increases that are unaffordable to the majority of South Africans.

I met with the private hospital groups and medical schemes to understand the reasons for their increases. It is clear from these meetings that none of them are prepared to accept responsibility for these high costs; each sector is blaming the other for the high costs. The private hospitals argued at the meeting that they cannot discuss details of their cost structures with their competitors being present. A team from the Department then met with the hospital groups individually to discuss their cost structures. I proposed that private hospitals limit their increases to CPIx. They agreed to consider this proposal and report back to me. I will be meeting with the hospital groups to discuss this matter.

There have also been reports of overbilling of inhalational anaesthetics. The overbilling of inhalational anaesthetics is in contravention of the medicine pricing regulations. I reminded the private hospitals that they are violating the law with regard to charging for anaesthetic gasses and they should desist with immediate effect or they will face prosecution in terms of our legislation.

The three cost drivers in the private health sector are private hospital costs, specialist charges and medical scheme administration costs. Medicine prices used to be one of the top three costs. Medicine prices used to also increase

beyond inflation. However after our intervention with the medicine pricing regulations this has now declined.

One of the reasons for the high costs from providers relates to the inability of medical schemes (particularly the smaller schemes) to negotiate reasonable tariffs with large provider groups such as the private hospitals. We are currently investigating a legislative regime that provides a fair basis for negotiation between medical schemes and providers.

Medical schemes have also been increasing their premiums and decreasing benefit packages so scheme members are now paying more, for fewer benefits. These benefit options are often presented in a confusing manner and it is difficult for an ordinary South African to understand exactly what one is buying.

Our investigations suggest that the current administrative costs in the medical scheme industry are high and must be reduced. I have asked medical schemes to examine these high administrative charges. It appears that medical schemes have devolved much of the decision making to administrators. These administrators are profit making organisations and may not act in the best interest of the patient.

The Medical Scheme Amendment Bill will also be presented to Parliament this year. The Amendment Bill strengthens the governance structures of medical schemes thereby making the trustees and principal officer of the scheme more accountable for administrative costs within a scheme.

The Health Charter task team has also been discussing the challenge of making healthcare more affordable. However these discussions are taking much longer than we had anticipated with no indication of the outcome. I have therefore decided that the current challenges in the private sector are best resolved through legislative interventions. The resolutions in the Health Indaba mandated the Department of Health to introduce legislative interventions to address the high costs of private healthcare.

I intend meeting with the private hospitals and medical schemes shortly to discuss the above issues.

Collusive pricing practices

On the 11th February 2008, The Competition Commission has referred a case of collusion against Adcock Ingram Critical Care (Pty) Ltd ("AICC"), Dismed Criticare (Pty) Ltd ("Dismed") and Thusanong Health Care (Pty) Ltd ("Thusanong") for prosecution. Adcock Ingram Critical Care, Dismed and Thusanong are competitors who supply pharmaceutical products to the health care market. Tiger Brands, the owner of Adcock Ingram, is also cited because it is alleged that certain of its directors were aware of the collusion.

During 2005, the Competition Commission initiated an investigation into allegations of a cartel between these firms, as well as Fresenius Kabi South Africa (Pty) Ltd ("FKSA"). The Commission's investigation found that the parties were engaged in collusive tendering and market allocation, both of which are contraventions of the Competition Act. The conduct was designed to avoid competition between the colluding firms and to manipulate prices for pharmaceutical and hospital products.

Fresenius Kabi South Africa has confessed its involvement in the cartel and had agreed to co-operate with the Commission's investigation. It was therefore granted immunity from prosecutions in terms of the Commission's Corporate Leniency Policy.

Collusive tendering

The Department of Health annually invites tenders for the supply of pharmaceutical products, large volume parenterals, irrigation solutions, administration sets and accessories to its public hospitals. The Commission's investigation found that the representatives of the above companies held telephone discussions and meetings prior to the submission of their respective responses to the invitations to tender. In these discussions and

meetings they collaborated on their responses and discussed and agreed on prices. This involved the manipulation of prices for the pharmaceutical and hospital products with which the tender was concerned. The colluding firms agreed amongst themselves who would win the tenders and, to give effect to this agreement, the terms of their respective bids. They would also agree that whenever tenders were not awarded as agreed or arranged between them, the winning firms would cede portions of the tender to one of their colluding partners. The Commission's investigation also found that the alleged conduct came to the attention of several board members of Tiger Brands, but no action was taken.

Market allocation

The Commission also found that Adcock and Fresenius Kabi were engaged in dividing markets in the supply of pharmaceutical products and services to private hospitals, including Life Healthcare Group Holdings, Network Healthcare Holdings Limited, Medi-Clinic Corporation Limited and mine hospitals. This involved them agreeing who would provide which products and to which hospitals.

The Commission has evidence that senior officials of each of the firms involved held meetings and telephone conversations to agree on the rigging of bids and allocation of markets.

The findings of the Competition Commission will be presented to the Competition Tribunal for a decision.

I must take this opportunity to congratulate the Commission on the good work they have done in uncovering these price fixing practices. Collusive behaviour is undoubtedly be one of the contributing factors to higher prices in healthcare markets This finding is significant in that it highlights one of the areas we must continue work on to reduce the collusive pricing practices.

We will be reviewing the current tender processes with National Treasury so that we take the necessary measures to discourage collusive pricing practices.