



Genesis Analytics

An economic consultancy based in Johannesburg working in the following healthcare areas:

- Competition economics
- Health policy
- Pharmacoeconomic analysis



Purpose of the presentation

BHF asked for a “health economist’s view of competition in healthcare”:

- Possibility of an exemption application
- Possible gains from co-ordination and co-operation between schemes

I argue that a “broad based” exemption is warranted for information sharing about providers (and for attempts to get that information from providers) but only a “narrow based exemption” is justified for the joint negotiation of tariffs.



Structure of the presentation

- The importance of competition in general and its role in healthcare markets
- Joint tariff setting
- Information provision, possibilities and perversions



The value of competition

The process of effective competition:

- Well informed consumers choose between a number of firms on the basis of “value for money”
- Companies have to offer “value for money” or they will lose sales to their competitors
- This drives companies to focus on prices (costs) and quality (innovation)



Progress in the international car market

1988	2007
BMW 325	BMW 328
	Air bags, ABS brakes, more reliable and fuel efficient etc.
R315,000 (\$45,000) (1988 US price converted into 2007 US\$ figures then converted into Rands at R7/\$)	R226,000 (\$32,400) (2007 US\$ figure converted into Rands at R7/\$)



Progress in the PC market

1988	2007
IBM PS/2	Dell Inspiron 531s
CPU speed: 20 MHz	CPU speed: 1.6 GHz (75 times faster than 20MhZ)
R8,269 (\$1,200) (1988 price converted into 2007 US figures and then converted into Rands)	R2,433 (\$349) (2007 US figures converted into Rands)



Why does competition not work in healthcare markets?

- **Insurance:** medical scheme reimbursement means that consumers do not directly pay for services and products
- **Information asymmetry:** consumers are not fully informed about the quality of care either before or after it is provided
- **Concentration:** few competitors, high barriers to entry (especially in localised markets)



Where the market works well

Survey of patients in US, Canada, UK and others

	<u>Bed side manner</u> Doctors <u>did involve the patient</u> in care decisions as much as patients wanted	<u>Waiting times</u> Waited less than four weeks to see a specialist doctor
US (market system)	84%	77%
Canada (state)	73%	43%
UK (state)	78%	40%



Where the market works less effectively

Survey of patients in US, Canada, UK and others

	<u>Clinical outcomes</u> Any error in past two years (information asymmetry about quality of care)	<u>Cost</u> Average expenditure on healthcare (WHO figures for 2004)
US (market)	34%	\$6,000
UK (state)	22%	\$3,000
Canada (state)	30%	\$3,000



A consequence of insurance and information asymmetry



Joint tariff setting

Prior to the Commission's prohibition in 2004 (arising from investigations in 2002/2003) tariffs were negotiated by:

- Medical Schemes: the Board of Healthcare Funders (BHF)
- Medical doctors: the South African Medical Association (SAMA)
- Hospitals: the Hospital Association of South Africa (HASA)

Leading to the publication of respective “tariff books” by each organization for use by their members



Rationale for joint tariff setting

Schemes presumed to be in a poor bargaining position.

There are 131 schemes represented by 17 administrators. They negotiate with:

- Three major hospital groups (\pm 80% of beds nationally)
- Few specialists especially on a regional level (average of only 180 specialists per field nationally)
- General practitioners, seven thousand nationally
- Others



The economics of joint tariff setting

Three scenarios:

- The featherbed: push prices down with only positive effect
- The waterbed (a technical economic term): push prices down in one area they come up elsewhere (i.e. consumables in hospitals)
- Monopsony: break providers' backs by pushing prices down too low (i.e. GPs)



Insurance and supply induced demand

Modern Medicine

"Well, Bob, it looks like a paper cut, but just to be sure let's do lots of tests."



Impact of joint tariff setting on hospitals

Joint setting of only some prices means that pushing down prices in one area leads to higher prices and utilisation in another:

- Consumables (making up 10% of costs)
- Utilisation (i.e. provide more services at the lower price)

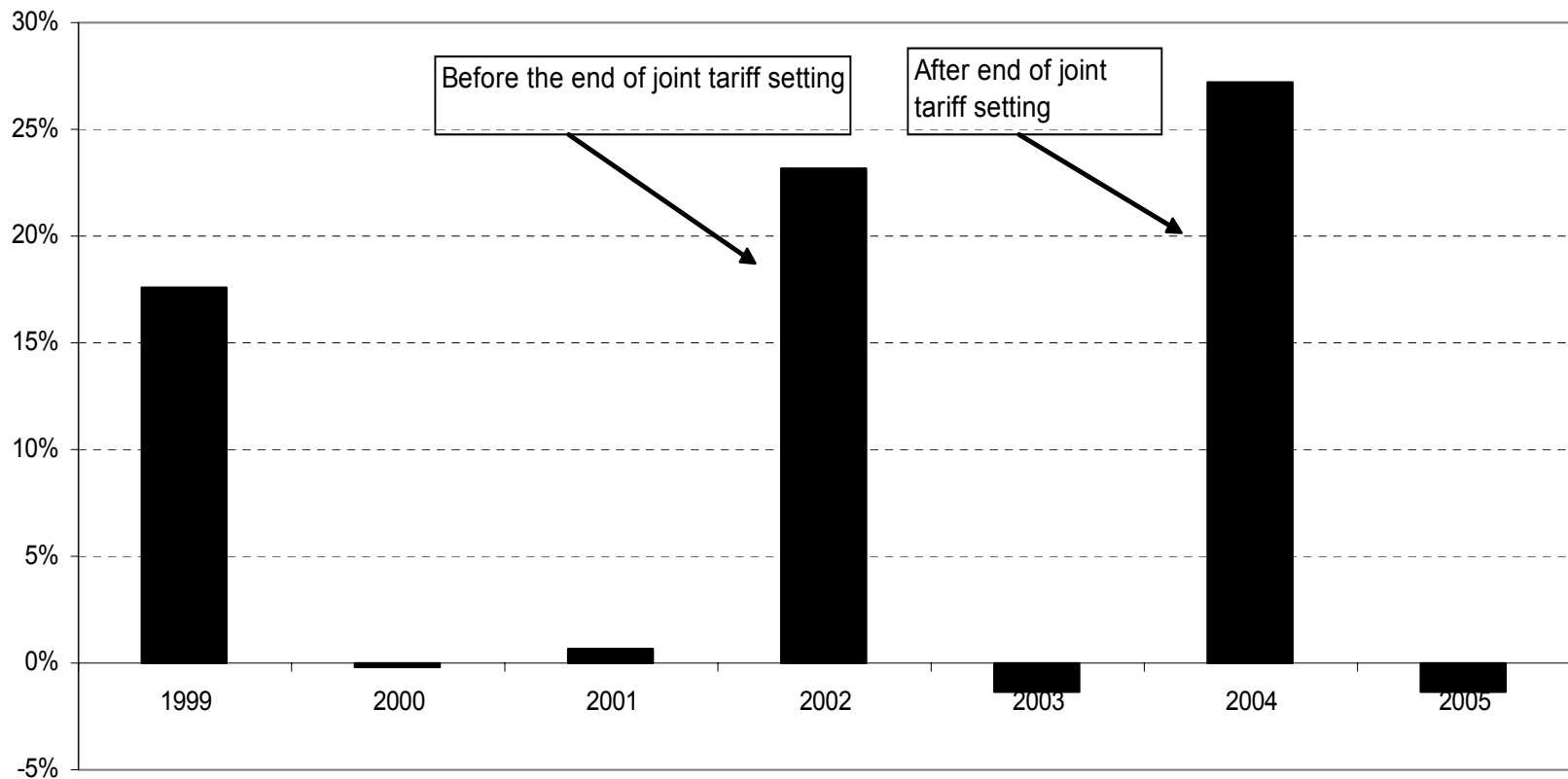
“Afrox Healthcare and Medi-Clinic, SA's two largest players in the private hospital sector after Netcare, have written to medical scheme administrators saying they planned to increase ward and theatre fees up to 28% to counter government's drive to lower medicine prices.”
Healthlink Bulletin 13-08-2004



Hospitals

Tariff setting period

No tariff setting



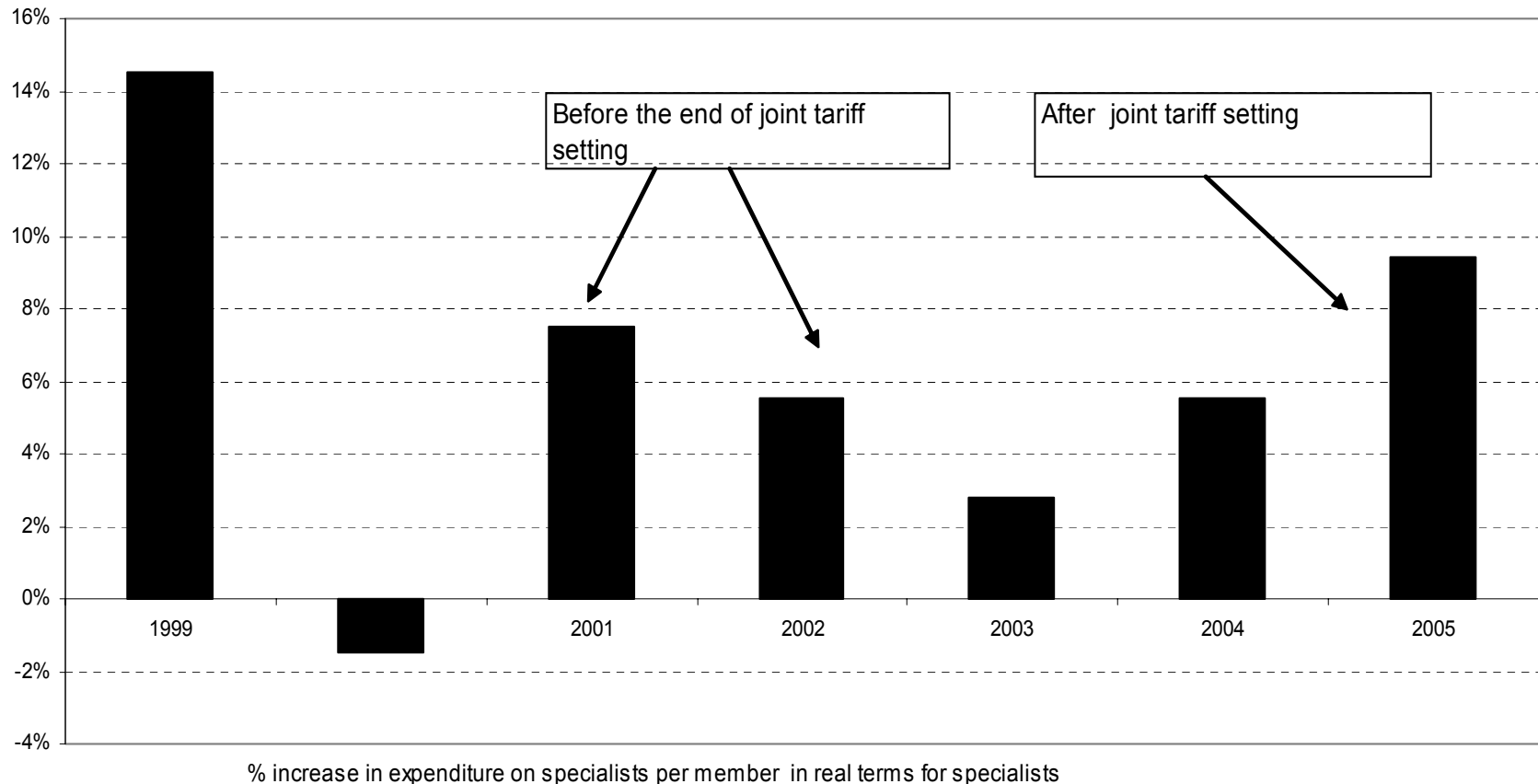
Percentage increase in hospital expenditure per member (real terms)



Impact of end of tariff setting on specialist costs

Tariff setting period

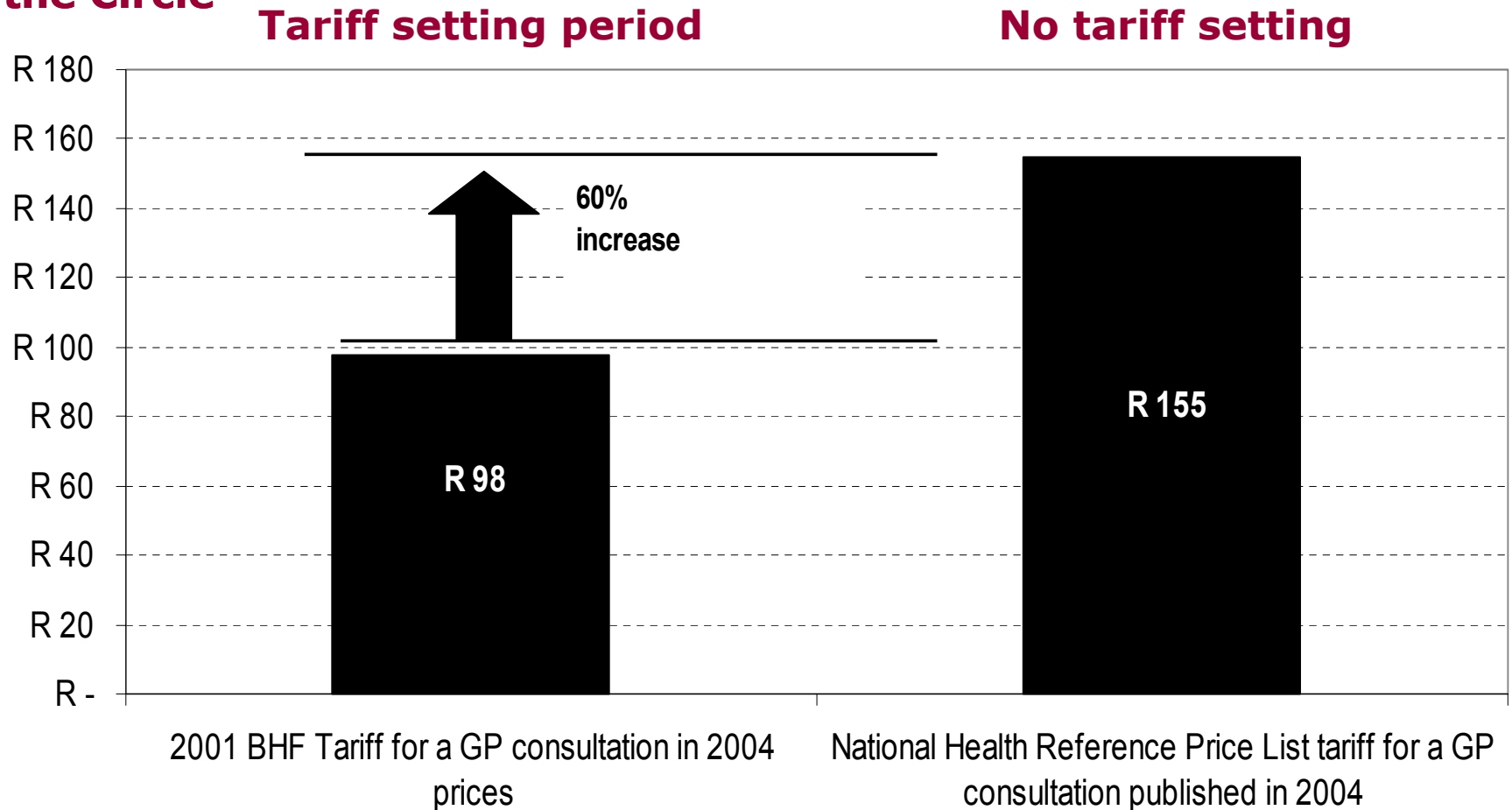
No tariff setting





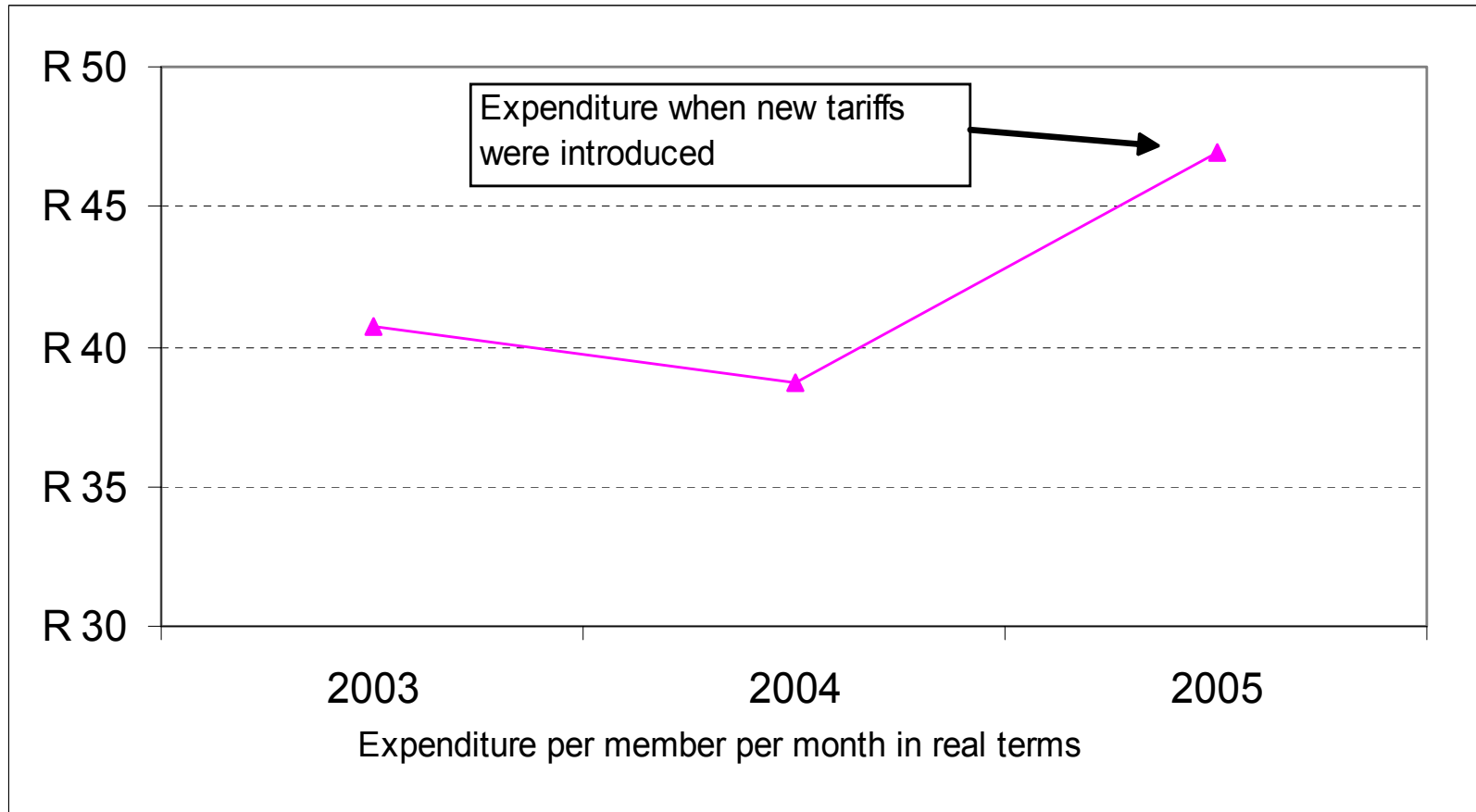
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Impact of tariff setting on General Practitioners





End of joint tariff setting on General Practitioners





Implications for joint tariff setting

- No clear benefit from the practice in light of the way it was implemented (hospitals and specialists who have bargaining power)
- Clearly socially damaging in certain circumstances (i.e. GPs where there are 7,000 in private practice and so risk of Monopsony)
- Suggests that Commission's decision was appropriate and exemption should only be granted on a case by case basis, perhaps for small schemes



Information sharing on providers

- Information asymmetry and lack of transparency are key failings of health care markets
- Generating and sharing information on:
 - Quality
 - Prices

Has the potential to increase competition

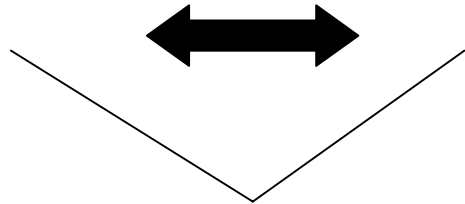


Issues with sharing information

- Significant benefits for hospitals and doctors to receive information allowing them to evaluate their own performance
- Complication rate data needs to control for case mix
- Even, with case mix adjustment (accurate measure of quality) directing consumers on the basis of complication rates will lead to cream skimming as hospitals turn away the sickest, most likely to experience complications, patients
- Potential benefit is that “units” compete rather than doctors

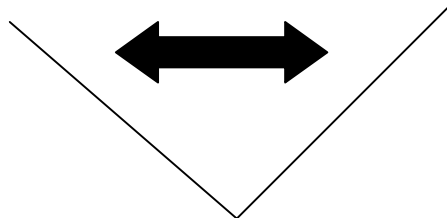


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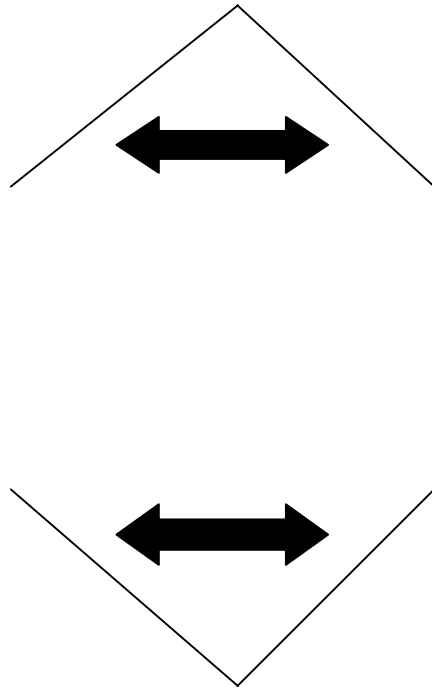


Hospitals compete to attract doctors and so patients

Doctors compete to attract patients and select between hospitals



Patients select between any number of doctors on the basis of the information available to them



**Doctors choose
between working at
different units**

**Units compete to attract
patients and doctors
providing an incentive to
improve reputation and
provide unit wide quality
improvements**

**Patients select between
medical units on the of
aggregated information
on performance**



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Key issues:

- Schemes should collect and share information on providers
- Schemes should be able to collectively negotiate with providers for access to information

Competition Authorities should consider broad based exemption covering these issues



Conclusion

Competition Authorities

- Caution should be showed towards joint tariff setting
- Co-operation around sharing and gathering information should be facilitated