

Briefing to the Portfolio Committee on Health
Tuesday, 26 February 2008
Minister of Health

PRIVATE HEALTHCARE COSTS

In October 2007 I convened a Private Sector Indaba to discuss my concerns about the unaffordable high costs in the private healthcare sector. At this Indaba everyone agreed that all was not well in the private health 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 over-billing of anaesthetics gases. The over-billing of anaesthetics gases 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.

We are particularly concerned with the lack of transparency in costs within the private healthcare sector. Last year we introduced regulations relating the development of a reference price list that takes account of the true cost of a particular service. We anticipate that this process will bring greater transparency to private healthcare costs.

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

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 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 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.

Dual Therapy

After much discussions between policy makers and scientists, the Department of Health introduced the prevention of mother-to-child transmission of HIV (PMTCT) programme in 2001. The programme was first piloted to explore the impact of the use of monotherapy and the possibility of resistance to a single drug as well as the lack of clarity on infant feeding options. The presentations by the scientific community also suggested that the use of monotherapy needed further research. But whilst these discussions were taking place, the Constitutional Court ordered otherwise, in 2002, the implication of which resulted in the expansion of the Nevirapine use without adequate requisite preparations.

Recent research and advice from experts now suggests that dual therapy is indicated. After consultation between the Department of Health and experts it has been decided that the PMTCT guidelines should be revised and that dual therapy, using Nevirapine and AZT should be used instead of Nevirapine only for the prevention of the transmission of HIV from mother to child. Given the complexities of prescribing antiretrovirals especially to children it has been decided that only registered health professionals, in line with the relevant legislation and regulations, should be allowed to prescribe AZT. It should be noted that this has not been an easy decision given lack of unequivocal scientific data and programme evidence on safety and effectiveness.

This programme must be seen as part of the comprehensive approach to the challenges presented by the HIV. It is also critical

that as we implement these revised guidelines that we provide the highest possible quality of care to both mothers and infants

There are issues I would like to clarify which has been the subject of debate:

(i) On Tail Regimen-

Even though this (Tail) position is recommended by the WHO in the 2006 PMTCT guidelines, there is no agreement among experts as to the risk/benefit analysis of this approach. The National Essential Drug List Committee (NEDLC) was not totally satisfied with the evidence presented. Specifically the recommendation is based on a study where the primary outcomes of only about 130 women-baby pairs were analysed. This sample is too small to inform public health policy in a convincing way.

Other combination studies that were cited involved the use of “tail” drugs other than AZT and 3TC, which cannot be used to corroborate data on AZT/3TC tail. AZT and 3TC are not without resistance problems of their own, especially 3TC.

(ii) ON CD4 Count

The “When-to-start” debate around HAART has not been resolved internationally. There does not seem to be any specific biological reason to treat pregnant women differently regarding commencement of HAART. The national adult ART guidelines are being reviewed to consider current evidence on this and other related matters. This will provide guidance also for the management of pregnant women as most of these women will be

referred to the CCMT service points. Until that has been done, the standard defined in the national treatment guidelines is the standard for the public health sector in this regard.

There is always consideration of new information and how it impacts on the programmes and whether we may need to improve policy.

(iii) Implementation Process:

The implementation plan for the new PMTCT guidelines have been developed to guide expansion of the programme with the aim of ensuring universal access to PMTCT services across the country. The implementation of the guidelines require an increase in the 2008/09 budget for PMTCT from R85 million to R281 million. Request for additional resources is to be made to Treasury in a bid for 2008 adjustment.

I thank you