

Competition Regulation in Healthcare in South Africa

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Introduction

Competition regulation in South Africa took significant shape in 1998 with the enactment of the Competition Act, following a transition in 1994 from a repressive political regime into a democratic state. There are traces of some regulation of anti-competitive conduct from 1907, then some competition regulation legislation between 1923 and 1944 followed by the Regulation of Monopolistic Conditions Act of 1955, with government (represented by the Minister of Trade and Industry) playing a regulatory function (OECD, 2003). Seemingly, the Regulation of Monopolistic Conditions Act of 1955 never made any meaningful impact, leading to a commission of inquiry in 1975, the Mouton Commission.

The Mouton Commission recommended changes to the legislation with a new competition law passed in 1979 (the Maintenance and Promotion of Competition Act of 1979), introducing some changes allowing for the establishment of the Competition Board with some investigative powers, but still no decision-making powers (OECD, 2003; Lesofe and Nontombana, 2016). With most economic activity controlled by the state and laws that permitted certain anti-competitive practices, mainly through marketing boards and trade protection measures, South Africa's economy was bound to be highly concentrated and susceptible to anti-competitive practices, something the competition laws that existed prior to 1994 never addressed.

Abstract

South Africa's nascent competition regulatory regime is coming of age and has potential to address historical market concentration challenges previously enabled by the apartheid regime, prior to its dismantling in the 1990s. Many sectors of the economy are highly concentrated, including the private healthcare sector, with market outcomes that breed market failures, lack of competitiveness and high cost of care. Looking through competition in the healthcare sector it becomes evident that the market structure challenges do not only require domestic interventions, but also a global response to address some policy and regulatory gaps.

El incipiente régimen de regulación de la competencia de Sudáfrica está llegando a su madurez y tiene el potencial de abordar los problemas históricos de concentración del mercado que el régimen del apartheid permitió antes de su desmantelamiento en la década de 1990. Muchos sectores de la economía están muy concentrados, incluido el sector sanitario privado, con resultados que engendran fallas de mercado, falta de competitividad y alto costo de atención a la salud. Al analizar la competencia en el sector sanitario se hace evidente que los retos de la estructura del mercado no sólo requieren intervenciones nacionales, sino también una respuesta global para subsanar algunas lagunas en las políticas y regulaciones actuales.

Le nouveau régime de réglementation de la concurrence de l'Afrique du Sud arrive à maturité et peut permettre de remédier les problèmes historiques de concentration du marché que le régime de l'apartheid, avant son démantèlement dans les années 1990, a favorisé. De nombreux secteurs de l'économie sont fortement concentrés, notamment le secteur des soins de santé privés, avec des résultats commerciaux qui engendrent des défaillances du marché, un manque de compétitivité et un coût élevé des soins. En examinant la concurrence dans le secteur des soins de santé, il devient évident que les défis liés à la structure du marché ne nécessitent pas seulement des interventions nationales, mais aussi une réponse mondiale pour combler certaines lacunes des politiques et réglementations actuelles.

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The Competition Act adopted in 1998 inscribed in its preamble that “(t)he people of South Africa recognise... (t)hat apartheid and other discriminatory laws and practices of the past resulted in excessive concentrations of ownership and control within the national economy, inadequate restraints against anti-competitive trade practices, and unjust restrictions on full and free participation in the economy by all South Africans.” The 1998 law is one of the central pieces of legislations the democratic government adopted to transform the South African economy for participation by the majority of the population previously excluded because of race and creed. As such, in all aspects of competition regulation there are embedded principles of not just competition law enforcement, but redress of past socio-economic injustices.

The 1998 Competition Act broke away from the past ineffective regulatory regime and established three independent institutions, namely, the Competition Commission tasked with investigative and prosecutorial powers, the Competition Tribunal as an adjudicating body as well as a Competition Appeal Court to hear appeals. Lewis (2012) notes that for the new competition regime to be effective, the three institutions tasked with the implementation of the law needed to be independent from political influence, but also independent from each other. With the new institutional arrangements, Lewis (2012:2) observed that “(t)he investigations of the Competition Commission and the hearings of the Competition Tribunal have illuminated many of the dark corners of South African business.” It is the robustness adopted in the execution of the new competition regulation regime that has enabled South Africa to uncover and prosecute various forms of anti-competitive practices, especially cartels to fix prices.

With just over 20 years of enforcement, the challenges of concentration in various sectors of the economy persist (Buthelezi, Mtani and Mncube, 2019; Roberts, 2020), and many sectors are still at the levels of concentration akin to those that prevailed in the apartheid-era economy. Since 1999 the government has twice made major revisions to the competition law, with the last amendments effected in 2018. The 2018 amendments seek to strengthen provisions to address market dominance and the high levels of concentration in markets.

The focus of this paper is on competition in healthcare markets in general, but with focus on South Africa whose healthcare markets are largely characterized by high levels of concentration, and unaffordable to many. Healthcare in South Africa is provided by the state and the private sector, with the former serving approximately 83 per cent of the

population and the latter 17 per cent but disproportionately with equivalent spend (CCSA, 2019)¹. The high expenditure in private healthcare could be an indicator for high cost of care in the private sector or inadequate care in the public sector, but an inquiry into the cost of private healthcare in South Africa found the cost of care to be unduly high relative to comparative markets globally and that the market was prone to market failure. With COVID-19 it is also imperative that citizens access healthcare at affordable and competitive prices, even for public facilities as they too largely depend on access to supplies from firms that provide pharmaceuticals, equipment, and other healthcare essentials.

From a competition regulation perspective, the focus in healthcare markets has been through merger control, prosecution of market abuse and collusion, general investigations as well as advocacy. It therefore is necessary to consider some outcomes of these interventions in the context of the findings of South Africa’s market inquiry into private healthcare in 2019 pointing to persistent market failures and regulatory lapses.

Merger Control in Healthcare

Merger control regulation seeks to prevent concentration in markets through mergers between competing firms. The regime adopted in South Africa is one that balances competition, competitiveness and broader socio-economic goals such as employment and economy-wide impact.

Although most mergers filed in South Africa have been approved (per Figure 1), where competition or public interest concerns have been identified these have mainly been remedied through conditions with fewer outright prohibition of mergers.

There have been significant market structure changes in the broad healthcare market – consolidation of private hospitals with the three large private hospitals accounting for 90 per cent of the market as well as in the medical insurance scheme and associated administration which saw the number of schemes decreasing from 163 in 2000 to 81 in 2017 (CCSA, 2019). Competition in the private sector occurs at various levels, mainly, hospital services, medical insurance, administration of medical insurance schemes. The public sector offers a unitary service provided by government largely at no cost to the public, as such competition regulation has limited application.

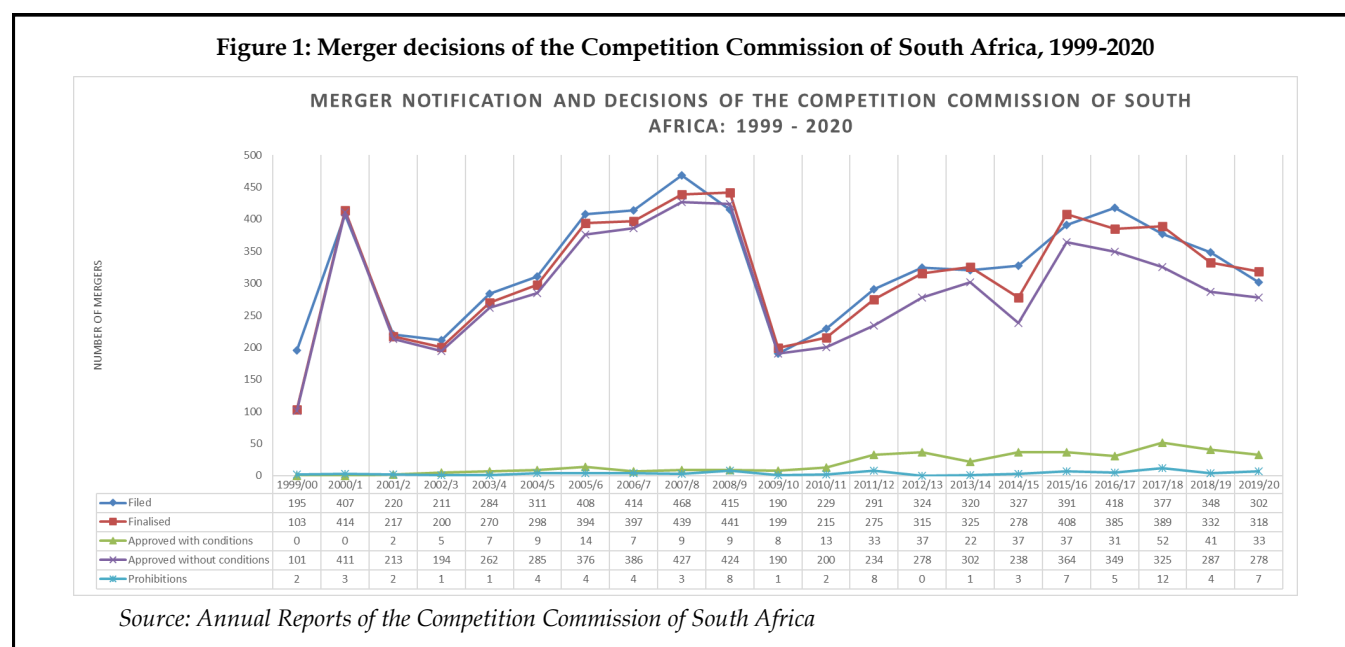
The private healthcare market inquiry also found that the merger control regime in South Africa has been permissive and unable to prevent anti-competitive creeping mergers. The consequence of this outcome is that the main segments of the healthcare markets is dominated by few large players resulting to inadequate levels of competition. There may be a need to review or

strengthen the merger control regime to address concerns of market concentration, particularly as major structural changes in the healthcare markets have been through mergers.

To illustrate the potential consequences of anti-competitive mergers, in 2014 Pfizer, a US pharmaceutical company, attempted to acquire AstraZeneca, a UK-Sweden pharmaceutical company. The attempted merger failed as policymakers in the UK and society in general opposed the transaction, forcing Pfizer to pull out. It is not known what the outcome would have been had the transaction been filed with affected competition authorities. What is known, and with the COVID-19 pandemic, is that the two companies have been at the forefront of developing a vaccine for COVID-19, which outcome would not have been possible had the merger proceeded.

was prosecuted, GSK and BI agreed to settle the complaints. GSK and BI agreed to (a) grant licenses to generic manufacturers, (b) permit the licensees to export the relevant antiretroviral drugs to sub-Saharan African countries, and (c) where the licensee did not have manufacturing capability in South Africa, permit the importation of the antiretroviral drugs for distribution in South Africa only, provided all the regulatory approvals were obtained.

The Competition Commission’s settlement of the case with GSK and BI immediately resulted in significant price reductions, which persist to this day (see figure 2). The lower prices of antiretroviral drugs allowed for affordable access to medicine by those living with HIV/AIDS, and equally allowed government to provide access to these medicines.



Addressing Cost of Access to Healthcare

In South Africa, the prosecution of market abuse has yielded significant outcomes particularly as this relates to the supply of antiretroviral drugs. The Competition Commission intervened in 2003 when it received a complaint from individuals infected with HIV/AIDS, health care professionals, trade unions, and several NGOs, who had complained of the conduct of GlaxoSmithKline (GSK) and Boehringer Ingelheim (BI) – this case is commonly known as the Hazel Tau case, one of the individuals who complained at the time. The complainants accused GSK and BI of charging excessive prices for their patented antiretroviral drugs.

The Competition Commission found that GSK and BI had abused their dominant positions in the sale of antiretroviral drugs and before the matter

The Hazel Tau case shows the benefits of competition regulation that seeks to remove artificial restraints to competition and discipline firms to price competitively.

From the beginning of the COVID-19 pandemic in early 2020, the Competition Commission shifted focus to price gouging and excessive pricing and investigated over 2000 complaints between March 2020 and February 2021, with the trend continuing as the pandemic worsens. Although a substantial and sudden increase in price does not offer sufficient evidence of market power or its abuse, consumers may suffer substantial welfare losses when competitive responses to such a firm specific price increase are muted or slow. Under these circumstances, a firm may be able to implement and maintain an increased price and, hence, margin. In the context of South Africa, like many

jurisdictions, government tasked the competition authorities to implement both the competition law and the consumer law regulations, with the Minister of Trade, Industry and Competition publishing regulations to stem price gouging and for the competition and consumer protection authorities to enforce these.

Promoting Access to Healthcare

In 2019, at its Intergovernmental Group of Experts meeting, UNCTAD convened a session on competition in healthcare markets focusing on access and affordability. The concerns of access to healthcare and affordability have been central to the discussions of the various

multilateral organisations over the years, however the challenges of access to healthcare and associated costs remain. In the discussion document contributed by the Competition Commission of South Africa, it is noted that the cost of healthcare continues to rise (UNCTAD, 2019). There are several factors that contribute to the high cost of healthcare including excessive pricing of pharmaceuticals, abuse of intellectual property rights and increased concentration in healthcare markets.

There are some recommended actions requiring that healthcare remains a priority to policymakers, including, collaboration

between sector regulators and competition law regulators, need to focus on competition issues in pharmaceuticals and healthcare markets (e.g., medicine pricing, pay-for-delay) as well as fostering cooperation among competition regulators to enable better and effective enforcement.

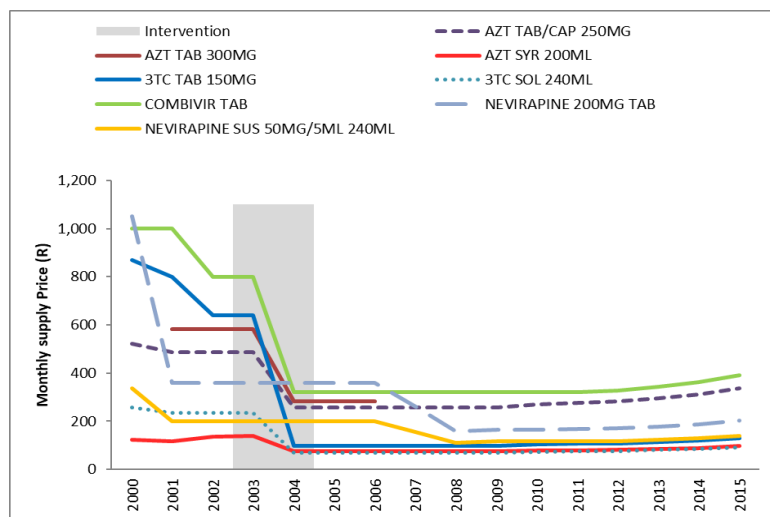
Competition policy remains an important tool to enable access to pharmaceuticals and treatment, at the lowest cost possible, whilst simultaneously balancing the need to promote investment and innovation.

Policy Developments

In 2018, South Africa adopted its realigned Intellectual Property policy, anchored on the Doha Declaration on TRIPS and Public Health, with initial focus on public health, with other areas to be determined in subsequent phases. The policy focuses on key areas such as local manufacture and export in line with industrial policy, patents substantive search and examination, patent opposition, patentability criteria, disclosure requirements, parallel importation, exceptions, voluntary licensing, compulsory licenses and the relationships between intellectual property and competition law.

Reforms of the form such as those being adopted in South Africa are timely and will ensure inclusive healthcare as well as an adequate response to the COVID-19 pandemic. It is evident as nations respond to the COVID-19 pandemic, particularly the develop-

Figure 2: Impact of enforcement on antiretroviral drugs in South Africa



Source: Competition Commission of South Africa

This was a pragmatic decision to make full use of the institutional strengths of the competition and consumer protection authorities to protect consumers during the pandemic.

Most complaints were on rising prices of facial masks, hand sanitizers and food items such as garlic and ginger. There was some scepticism on the appropriateness of competition regulation in tackling price gouging as a form of excessive pricing in completion law doctrine, but as Ratshisuus and Mncube (2020) argued, there are circumstances where competition regulation can be applied. For the period March 2020 and February 2021, 31 firms were prosecuted in South Africa for charging excessive prices for essential protective products as well as basic foodstuffs, with most of the firms reaching a settlement with the Competition Commission to pay a fine, reduce prices and/or donate the essential products to affected consumers. These enforcement interventions ensured that prices of essential goods during the COVID-19 pandemic did not unreasonably escalate, to the benefit of consumers.

It is evident that fair competition principles ought to be applied in markets, as firms looking to profiteer from healthcare exist, and it is these firms that should not only be subjected to competition regulation but also other complementary regulatory interventions to prevent the exploitation of those in need of healthcare.

ment and distribution of vaccines, that there is a need to essential pharmaceuticals to be accessible and affordable. In this regard, recent steps taken by India and South Africa in the World Trade Organization calling for the suspension of the protection of the IP related to COVID-19 health products signal the need to look broadly into measures necessary for equitable access to healthcare and acceptable pricing practices for pharmaceuticals. This initiative for waiving some provisions of TRIPS is supported by some countries with those opposed to it arguing that the TRIPS provisions suffice. As CUTS International (2020: 27) observed, for those opposing “(t)he idea is that IPRs [Intellectual Property Rights] do not create barriers to timely access to affordable medical products or to scaling up R&D, manufacturing and supply of such products to combat COVID-19.”

CUTS International (2020) has proposed a *Toolkit on Competition Policy and Access to Healthcare*, which is a timely reminder of the need for nations for adopt measures to improve access to healthcare and affordability. The toolkit advocates for the adoption of uniform rules that ensure firms do not abuse intellectual property rights and stifle competition, but more pertinently, it recognizes that “(t)o keep the market competitive, competition law enforcement alone may not be sufficient. First thing that is needed is an enabling policy environment that promotes competition in the market, including removal of entry barriers and market distortions, and inducing ease of doing and running businesses” (CUTS International, 2020: 2).

Conclusion

It is increasingly evident that for access to healthcare to be equitable, measures beyond the existing regulatory and policy architecture must be adopted, otherwise the status quo will remain for years to come. There is firm level conduct such as abuses of intellectual property rights, collusion and anti-competitive market dominance that regulation, particularly competition regulation, has been able to address. However, competition regulation has largely addressed market abuses *ex post*, and what is also required are *ex ante* regulatory and policy interventions. There is therefore a need for multilateral organizations, mainly WTO and UNCTAD, to revisit healthcare markets and assess the effectiveness of measures currently in place to promote access and affordability of healthcare in general. The COVID-19 pandemic, by affecting all nations at the same time, has exposed the policy and regulatory gaps, which now call for an urgent coordinated global response.

Endnotes:

¹ Broadly, the expenditure of private healthcare sector is about 4.4 per cent of South Africa’s GDP, while government’s expenditure on healthcare is about 4.1 per cent of GDP.

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