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A. BACKGROUND

1. On 29 November 2013, the Competition Commission (“the Commission”) announced that it would conduct a Market Inquiry into the private healthcare sector (“the Inquiry”) and published the Terms of Reference for the Inquiry (“the Terms of Reference”).

2. In initiating the Inquiry, the Commission indicated that it had reason to believe that there were certain features of the private healthcare sector that prevent, distort or restrict competition. In setting out the rationale for the Inquiry, the Terms of Reference state that “[v]arious concerns have indeed been raised about the functioning of private healthcare markets in South Africa as a result of the fact that healthcare expenditure and prices across key segments are rising above headline inflation. These increases in prices and expenditure frame the Commission’s inquiry into the sector.”

3. The Terms of Reference state that through conducting an analysis of the private healthcare market “the inquiry aims to identify all factors that prevent, distort or restrict competition, including any evidence of market failure, regulatory failure or competition concerns” and that this “will provide a factual basis upon which the Commission can make evidence-based recommendations that serve to promote competition in the interest of a more affordable, accessible, innovative and good quality private healthcare.”

4. In this respect, the issues of price and expenditure were central considerations in the Inquiry, and this is particularly relevant when assessing the HMI’s findings in relation to these key features of the Inquiry. In addition, the HMI itself recognised that its findings and recommendations had to be based on factual findings, which were drawn from objective evidence. In other words, the findings and recommendations could not be

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1 The Terms of Reference state that the private healthcare sector comprises a number of interrelated markets and divide these into three broad categories: (1) financing of healthcare (including medical schemes, medical scheme administrators, managed care organisations and healthcare insurers); (2) providers which include facilities (hospitals, day clinics, sub-acute facilities, specialised care centres and other similar facilities) and practitioners; and (3) consumables (pharmaceuticals, medical devices and other consumables). We note, that for reasons that have never been fully explained the third broad category “consumables” has been completely ignored by the HMI in the Inquiry. This is despite the fact that Netcare made submissions, both orally and in writing, as to the price difference in consumables between South Africa and the United Kingdom and the impact thereof on the functioning of private healthcare markets in South Africa.


3 Terms of Reference, page 81, our emphasis.
premised on speculation or mere hypothesis, but had to be grounded on verifiable analysis and objective facts.\(^4\)

5. On 5 July 2018, the HMI\(^5\) published its Provisional Findings and Recommendations Report ("the Provisional Report") and invited submissions in response to the Report. Following its publication of the Provisional Report the HMI received 67 submissions from various stakeholders, including an extensive paper filed on behalf of Netcare, commenting on the Provisional Report.

6. Following the receipt of the various submissions by stakeholders in respect of the Provisional Report, the HMI convened three seminars in relation to certain key areas of focus, namely: (i) Facilities Concentration and Remedies, (ii) Funder Concentration and Countervailing Power, and (iii) Supply Induced Demand.

7. Prior to the holding of the seminars, the HMI published three seminar notes. The first dated 19 February 2019 related to Facilities Market Concentration and Remedies, the second related to Funders’ Market Concentration and Countervailing Power (20 February 2019), while the last note was titled “Excessive Utilisation and Supplier Induced Demand” and was published on 22 February 2019.

8. On 2 April 2019, the HMI then published two further, more detailed, seminar notes. The first related to so-called facilities concentration and the second dealt with the funder market. A third detailed seminar note was published on 5 April 2019 in relation to what the HMI called “Excessive Utilisation and Supplier Induced Demand”.

9. The three seminars were respectively held on 9 April 2019 (Facilities Seminar), 10 April 2019 (Funder Seminar) and 12 April 2019 respectively (Excessive Utilisation and Supplier Induced Demand Seminar). At the conclusion of the third seminar on Supply Induced Demand, the HMI Panel requested that stakeholders prepare a final submission, highlighting areas of consensus amongst stakeholders and the HMI, as well as any areas which remain in dispute. This invitation forms the basis for this submission.

\(^4\) For a more detailed summary of the background to the Inquiry process please have regard to Netcare’s submissions on the HMI’s Provisional Report dated 15 October 2018.

\(^5\) In these submissions, when we refer to “the HMI”, we mean this as a collective reference to the Panel appointed to conduct the Inquiry and the Competition Commission staff that have worked with and assisted the Panel in the conducting of the Inquiry. Where it is necessary, we will refer separately to the Panel.
10. In what follows we provide an overview of the HMI’s initial position in relation to the two key areas of concentration and so-called supply induced demand based on its findings in the Provisional Report, highlighting where the subsequent detailed seminar notes, which were published in February 2019, may have adopted in certain important respects a somewhat different stance to that taken in the Provisional Report.

11. We also consider the issue of concentration levels in relation to facilities and funders, in order to assess whether the HMI has applied a consistent approach to determining the need for remedies in the two sectors. This then brings into focus the HMI’s analysis of bargaining dynamics between facilities on the one hand, and funders on the other hand, in an attempt to understand whether there is parity of bargaining power and whether the private health care sector in South Africa is producing efficient market outcomes to the benefit of consumers at large.

12. Lastly, we assess the issue of the remedies which have been proposed by the HMI in respect of the key areas of focus being concentration and so-called supply induced demand, noting the importance of identifying where appropriate, proportional remedies which directly address and are in response to specific theories of competition harm which are cognizable in terms of competition law, which have been identified by the HMI during the course of its market inquiry. In doing so, we consider the submissions of various stakeholders during the seminars, underscoring areas of consensus, as well as areas of disagreement, and the implications of certain of the remedies, which have been proposed by the HMI.
B. FACILITIES CONCENTRATION

a) Introduction

13. In its Provisional Report, the HMI provisionally concluded that the national facilities market and various local markets were highly concentrated. The HMI noted that the “facilities market is characterised by high levels of concentration at both the national level and in a majority of local markets.”\(^6\) In addition, the HMI noted that “the national concentration levels provide a significant strategic advantage to the three largest facility groups – both individually and as a collective.”\(^7\)

13.1. At a national level, the Provisional Report concluded that the three largest hospital groups account for the overwhelming majority of the facilities market:

“[T]hree hospital groups, Netcare, Mediclinic and Life have a combined market share of 83% of the national South African private facilities market in terms of number of beds and 90% in terms of total number of admissions. With national Herfindahl-Hirschman (HHI) values of above 2 500, these national markets must be characterized as ‘highly concentrated’ by all internationally accepted criteria.”\(^8\)

“The three large hospital groups, Netcare, Life, and Mediclinic accounted for approximately 88.4% of acute in-patient beds nationally in 2015.

21 On a national basis, Netcare accounted for 33.3% of all acute in-patient beds, Life Healthcare for 28.8% and Mediclinic for 26.3% ... NHN and other independent hospitals and day clinics not affiliated to NHN accounted for 11.6% of acute in-patient beds nationally”\(^9\)

“The HHI and concentration ratio (CR3) for the national private hospital market is 2784 and 90.1% and 2521 and 83.2% based on admissions and registered beds respectively. If we consider the CR4, the combined market shares are 97.8% and 96.8% based on admissions and registered beds

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\(^6\) See the Provisional Report at page 197, paragraph 171
\(^7\) See the Provisional Report at page 197, paragraph 171
\(^8\) See the Provisional Report at page 11, paragraph 45
\(^9\) See the Provisional Report at page 169, paragraph 17
respectively. Based on these data, the private hospital market HHI is above the established highly-concentrated threshold and therefore conclude that the facilities market is concentrated at national level. Further, the market shares amongst the large incumbents are very high and have barely changed over time.”

At a local level, the Provisional Report stated that the majority of local markets were found to be highly concentrated:

“At the local level, 58% of the 195 local markets that the HMI has distinguished are also ‘highly concentrated’ as measured by the HHI and the Logit Competition Index (LOCI), which are both internationally accepted methods to assess market concentration at the local level.”

“Table 6.3 shows a total of 20 local markets with fascia counts equal to or below 1, without adjusting for hospital groups. Approximately 10% of the total unadjusted local markets have fascia counts equal to or below 1. Of these local markets, 11 markets (6%) face one competitor while 9 (5%) are considered solus hospitals.”

“After adjusting for hospital groups, the third column of Table 6.3 shows that there are a total of 28 local markets (14%) with fascia counts equal to or below 1. Of these local markets, 12 markets (6%) face one competitor while 16 (8%) are considered solus hospitals.”

“Based on the internationally most widely applied HHI concentration thresholds and before hospital group adjustments, 45 out of 195 local markets are highly concentrated. This accounts for 23% of the total local catchment areas. Of these highly concentrated local markets, 9 markets are solus hospitals in their catchment areas, accounting for 5% of the total local markets. The number of local markets that are moderately concentrated is 13, accounting for 6% of the total local markets. The number of local markets that are not

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10 See the Provisional Report at page 185, paragraph 120
11 See the Provisional Report at page 11, paragraph 46
12 See the Provisional Report at page 189, paragraph 135
13 See the Provisional Report at page 189, paragraph 136
concentrated – if unadjusted for group and network membership is 128, accounting for 66% of the total local markets."\(^{14}\)

"Adjusting for network membership, the HHI measure indicates 88 highly concentrated areas, accounting for 45% of the total local hospital areas. Of these highly concentrated local areas, 25 are served by solus hospitals, accounting for 13% of the total local markets. The number of local markets that are moderately concentrated is 13, accounting for 7% of the total local markets. The number of catchment areas that are not concentrated is 69, accounting for 35% of the total local markets. This shows that the hospital group adjustment has a significant impact on the levels of local concentration and that local hospital concentration in terms of catchment areas is very high in South Africa."\(^{15}\) (Our emphasis)

14. On 2 April 2019 the HMI published a detailed supplementary note for purposes of clarifying its findings on concentration, responding to certain criticisms on both its national and local market analysis. It also set out a revised concentration analysis, which limited the assessment to hospitals with 57 and 58 practice numbers. While the HMI continued, in the supplementary note, to assert the position that the national market and identified local markets were still highly concentrated, its subsequent analysis, in particular as far as national market shares are concerned, highlighted the fact that there had been a significant decrease in concentration both during the period of the HMI’s initial analysis (as reflected in the provisional report), as well as in subsequent years following the HMI’s more recent analysis (as reflected in the seminar note of 2 April 2019).

15. Indeed, the more recent HHI results produced by the HMI in the seminar note, reveal that all of the results fell below the (highly concentrated) threshold of 2500. For ease of reference these have been replicated below.

\(^{14}\) See the Provisional Report at page 189, paragraph 139
\(^{15}\) See the Provisional Report at page 189, paragraph 140
Accordingly, the most recent concentration analysis prepared by the HMI itself, appears to demonstrate that at a national level, the facilities market is not highly concentrated (even based solely on HHIs). This appears to be a position, which is now reasonably widely acknowledged to be correct.

**Netcare and other stakeholder perspectives on the HMI’s facilities concentration analysis**

Before reflecting on the submissions by various stakeholders in the April seminar on facilities concentration\(^{16}\), it is necessary to underscore the fact that concentration measures are of themselves, not determinative of the existence of competition harm in a particular market(s). While the HMI has placed significant reliance on concentration measures such as the HHI and the Logit Competition Index (“LOCI”), it is important to note that HHI calculations are imperfect measures and are no more than a starting point for a proper substantive analysis in order to establish whether any specific competition harm can be identified.

The South African Competition Tribunal ("the Tribunal") has previously found that HHI measures are not necessarily appropriate for assessing the degree of competition in differentiated markets such as hospital markets:

\(^{16}\) On 9 April 2019 the HMI held a seminar on facilities concentration. The HMI panel heard presentations from Netcare, Mediclinic, Life Healthcare, Medscheme and Discovery Health.
“...hospitals provide differentiated services, because they typically provide a bundle of services varying in range and kind. This means that the closer the similarity in services the greater the likelihood that they compete with one another or put differently, they may vary in the degree to which they may be considered competitors. As a consequence of this, conventional HHI analysis may throw up a skewed picture of a market as the extent of concentration it reveals may bear no relationship to the reality of competition.” (our emphasis)

and

“Looked at from a purely HHI perspective, with nothing else, these figures look alarming. But as Dr Stillman argues, and Dr Roberts does not dispute this, HHI’s are a starting point - a filter for agencies to determine whether a merger requires a more in depth look. Viewed in isolation they could offer a distorted picture of the state of competition. This is because hospitals are not homogenous providers of services. Modern private hospitals provide differentiated services. Whilst some offer a full range of services others choose to narrow their focus. To take an extreme example a maternity hospital may be next door to a hospital providing geriatric services - despite their proximity they are not competitors. Thus as Vistnes, in an article both the Commission and merging parties rely on for different propositions, states:

“HHI’s are likely to underestimate the competitive problem when the two hospitals are very similar (compared with other hospitals in the market) and to overestimate the problem if the merging parties are highly differentiated.”17 (our emphasis)

19. As noted by the Tribunal, “HHI’s are a starting point”18. Similar views have been expressed in the economic literature. For example, Massimo Motta has noted that HHI’s are a “first screening device”.19 As such, before drawing any conclusions on whether there was a particular competition harm which needed to be addressed, a more detailed economic analysis would have to be conducted.20

17 Netcare/CHG, Case No: 68/LM/Aug06 paragraph 33, page 14 and paragraph 50, page 19, (our emphasis).
18 Netcare/CHG, Case No: 68/LM/Aug06.
20 We note that this view that HHIs are a starting point and that HHIs may not be necessarily apt for assessing competition in differentiated markets such as hospital markets is consistent with views of the US FTC and DOJ in their Merger Guidelines, and in articles reviewing use of HHIs in hospital merger screening. See Garmon,
20. In addition, in response to questions from the Panel, Mediclinic reiterated this position when it noted in relation to HHIs that: “It is just a measure and it's a starting point so the fact that I think my view from what I was hearing this morning, what I have seen in the evidence is looking at concentration at the National level, it is not highly concentrated, it is not at a level that in and of itself the HHI number signals concern. In fact it actually is a threshold level below which one is typically not concerned about a merger or about the overall state of competition.”\(^{21}\)

21. Accordingly, the HMI should be cautious in seeking to draw definitive conclusions about market power and competition harm based solely on HHI measures. In this respect, there appeared to be clear consensus amongst stakeholders that “concentration” measures alone are not indicative of harm to competition and that the HMI needs to identify particular instances of harm to competition, which may allegedly arise as a result of concentrated markets (such as excessive pricing, refusals to deal or other forms of exercise of market power) before it can be determined whether any remedies are required. This is discussed in more detail in the section on remedies, where it is pointed out that there is a distinct lack of any compelling evidence of such effects.

(i) National market concentration

22. The submissions from various stakeholders during the seminar confirmed the view that the national private hospital market is not highly concentrated and that, in fact, the HHI for each year since 2010 was below 2500 and has been decreasing consistently over the period of assessment and continues to decrease. There also appeared to be a significant degree of consensus amongst both facilities and funders, that the NHN had grown significantly over the period of assessment and was now a credible fourth alternative facilities group, which funders could have recourse to in negotiations with the major three groups both at a national level, as well as in local markets\(^{22}\).

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\(^{22}\) This position was noted by Mediclinic who stated that “I think there is a consensus now that there are four strong hospital groups, each of which have a very large overall share and that there is a dynamic of competition that the three listed groups have been unable to prevent or deter which is another indication of competition and so I think with regard to your finding on concentration I think where the numbers reside now should give you comfort that it is at a competitive level not at a concentrated or concern level”. See Competition Commission Health Market Inquiry Seminar: Session 3 of 9 April 2019 at page 13.
22.1. Netcare’s experts noted in their presentation that, “Entry since 2014 by NHN and independents outpaced adds by Life Mediclinic and Netcare: leading to 4 large hospital groups.” This has resulted in the emergence of a credible fourth provider network which is able to bargain collectively and is an alternative to the major groups. The vast majority of new hospital beds have been added by the NHN and independent hospitals, with NHN growing from 5,245 hospital beds in 2010 to 10,228 beds in 2017.

22.2. In 2010, Netcare, Life, and Mediclinic accounted for roughly two-thirds of the hospital beds in South Africa. NHN played a significant role in national competition with its affiliates accounting for 16 percent market share. Independent hospitals (sometimes organised into small groups), had limited market share individually but collectively provided a competitive fringe to the other four market players accounting for 13 percent of hospital beds.

22.3. In addition to the difference in relative growth rates between NHN and the other hospital groups, NHN increased in stature when a larger share of hospitals became affiliated with it.

22.4. By 2017, as a result of new entry and because of additional hospitals becoming affiliated to it, the NHN hospitals accounted for more than 25 percent of the national market. The NHN affiliated hospitals have more beds than any of the three major hospital groups. Independent hospitals also constitute a significant competitive fringe in the market, accounting for nearly 10 percent of national market share. The collective share of Netcare, Life, and Mediclinic has declined by five percentage points over this period.

22.5. The NHN includes extensive operations across South Africa. The rise of a nationally prominent and locally relevant NHN has improved the competitive landscape for providers generally. In particular, competition and bargaining take into account credible alternatives at national and local levels. Moreover, the extensive expansion and record of entry by the NHN as well as independent entrants (and the larger hospital groups) demonstrates the lack of high barriers to entry in South Africa and contrasts

23 Compass Lexecon Presentation entitled “Seminar: Facilities’ Market Concentration and Remedies” dated 9 April 2019, at page 5
sharply with hospital entry conditions and trends in other countries.

22.6. Mediclinic’s experts noted in their presentation that “NHN/independents gained more beds post-2014 (1297 beds) than Life Healthcare, Mediclinic and Netcare together (946 beds). The NHN/independents’ market share therefore increased substantially relative to the big 3 groups’ market shares post-2014”\(^{24}\).

22.7. Discovery Health Medical scheme showed in its presentation that NHN’s share of its expenditure had increased from “13.3%” in 2015 to “15.4%” in 2018 at the expense primarily of the three large hospital groups.\(^{25}\)

22.8. Medscheme showed in its presentation that there was “[s]ome evidence of deconcentration since 2014”\(^{26}\) and that the “NHN growth has created additional competition - an alternative network.”\(^{27}\).

22.9. Medscheme also noted during its presentation that “what has changed and what has changed the dynamic quite considerably is that NHN has grown to an extent that now we have, they have got facilities in many different regions and for the first time now in the last two to three years they have actually become a contender to be a network anchor, so almost a stand alone, we typically when we have networks we normally sort of have two anchors to be able to cover some gaps and NHN is easily a contender now for one of those anchors and that definitely is a change in the market from where we were previously”\(^{28}\). (Our emphasis)

22.10. In addition, the growth of the NHN and independent hospitals is expected to continue into the near future. This very important insight was not included in the HMI’s Provisional Report. Netcare’s submissions to the HMI indicated that in the next few years approximately 93% of all new beds will be allocated to independent hospitals and NHN members.\(^{29}\) This was confirmed by Medscheme’s submission to the HMI, which confirmed that for 2019 it anticipated that the NHN and independents would

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\(^{25}\) Workshop 1: Facilities market concentration and remedies, 9th April 2019, at page 18.

\(^{26}\) HMI Seminar: Facilities Market Concentration and Remedies: Dr Jenni Noble, 9th April 2019, at page 7.

\(^{27}\) HMI Seminar: Facilities Market Concentration and Remedies: Dr Jenni Noble, 9th April 2019, at page 12.


\(^{29}\) Seminar: Facilities’ Market Concentration and Remedies: Margaret E. Calvert and Jeremy Nighohossian, Ph.D., 9 April 2019 at page 5.
account for approximately 91% of all new hospital beds in South Africa. More specifically, Medscheme stated during its presentation that:

“we are aware of approximately two thousand new acute and day beds that are opening from the beginning of this year, 85% of those are acute beds and only 9% are actually from the listed groups and that is about sixty acute beds and one hundred and twenty day clinic beds. So most of these are independent and mostly from our understanding will be actually part of the NHN grouping.

We are also aware of quite a few mergers and acquisitions of acute facilities that are intended, quite a few of these are from the NHN, some of the NHN groups that are actually buying existing facilities and I mean I think Netcare, part of the tribunal decision in terms of Akeso was that Netcare had to sell off Bell and Rand Clinics and the RH group is now buying that.”31 (Our emphasis)

23. In addition, other stakeholders also noted that “the majority [of new builds] are coming through the new builds which are predominantly NHN and Independent and historically disadvantaged groups”32.

24. Accordingly, one of the key points of departure in the HMI’s findings (both in the Provisional Report and in its subsequent note of 2 April 2019) that the national market is highly concentrated is not accurate. Indeed, the submissions by various third parties at the concentration seminar, and the HMI’s own most recent analysis, clearly demonstrate that the national facilities market is not highly concentrated (even based solely on HHIs). Beyond concentration measures, the evidence points strongly to lack of high barriers to entry, and to improved market conditions supporting competition among four hospital groups and a competitive fringe – and significant alternatives for funders and consumers. Indeed, as Medscheme noted during its presentation the HMI needs “to consider the current market dynamics, things have changed significantly in the last few years”.33

(ii) Local market concentration

25. In relation to its local market concentration analysis, the HMI confirmed both in the Provisional Report and its more recent note of 2 April 2019 that its preferred approach to defining geographic markets was to employ the controversial Lavielle methodology. There was a substantial amount of consensus amongst the economic experts of the facilities in particular, that the Lavielle methodology was inappropriate for identifying geographic markets in competition law matters and that, in fact, this methodology produced inconsistent and contradictory results.

26. Netcare’s experts noted that the Lavielle methodology was “novel and unconventional”, and was “unreliable and not consistent with standard merger or market definition methods (e.g., SSNIP test) for defining geographic markets and competitive alternatives.” In addition, it was also highlighted that the HMI’s preferred methodology for defining local geographic markets had “not been used before for market definition in South Africa or internationally.” The LOCI and HHI results (which were produced by the HMI’s preferred methodology), produced local concentration results which are “unreliable [and] contradictory” as “[o]ne in four catchment areas are classified as highly concentrated by one measure and competitive by [the] other.” This is illustrated in the following chart that shows the HMI’s HHI and LOCI measures for individual hospitals. The hospitals (dots) in the shaded areas include a large number of hospitals with inconsistent measures – highly concentrated and not highly concentrated:

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34 See the Provisional Report page 181 at paragraph 98.
35 See paragraph 10 of Seminar note on facility concentration dated 2 April 2019.
Furthermore, it was demonstrated by Netcare’s experts that the local markets defined by Lavielle-based HHIs, did not reliably show the competitive alternatives available for funders or for patients, particularly in urban areas. In this respect, it was shown that for nearby hospitals, within just 5km of each other, that the HMI’s preferred novel approach for estimating catchment areas and HHIs, would classify a large number of neighbouring facilities differently with respect to levels of concentration. Moreover, it was estimated that 96% of medical scheme beneficiaries are actually located in areas where neighbouring hospitals were identified with conflicting concentration measures (i.e. some hospitals in these areas were identified as being in concentrated markets while other neighbouring hospitals were at the same time classified as being in non-concentrated markets).

Certain examples of these contradictory results are depicted in the map below:

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40 While there may be some logic as to why nearby hospitals may not face similar competitive alternatives (e.g., a tertiary facility and a small hospital offering only limited services may have different competitive alternatives and may be less close substitutes for each other), the extensive set of inconsistent measures of alternatives within a local area indicates issues with the methodology and its results rather than these specific cases. The local concentration measures used by the HMI do not appear to depict well the competitive alternatives available to either funders or consumers, and are inconsistent with the strong evidence of funders excluding or selectively including hospitals in networks in these same areas.
28. Similar issues were raised in submissions made by Econex on behalf of Mediclinic, which noted that “[c]onclusions of concentration and ‘unexplained expenditure’ are based on ‘doubled’ categories: 15% of Enumerator Areas (EA’s) are linked to one category of concentration, almost half are linked to two; regions are concentrated and unconcentrated at same time”\(^{41}\) (Emphasis added)

29. These inconsistencies illustrate further that the individual hospital concentration measures used by the HMI to define “local markets” fail to capture the alternatives available to funders and to patients in a local geography or market area. These are only individual hospital measures, and not well-defined market areas, which should reflect the hospital alternatives available to patients or funders in a given area.

30. The HMI experts also presented some analyses examining the relationship between local (individual) hospital concentration measures and utilisation (admissions) and expenditure. Contrary to sound economic theory, they articulate a novel theory that competitive markets lead to over-utilisation and competition leads to negative outcomes. However, the reported analyses and results show no systematic relationship between local concentration and utilisation - moderately concentrated areas have higher unexplained utilisation than non-concentrated areas. Moreover, the HMI results are sensitive to changes in sample or model specification. For example, Mediclinic’s experts (Econex) critiqued the HMI’s local concentration-admission (utilisation) analysis as

being limited to only 24 of 195 hospitals, which accounts for only 12% of the HMI’s sample. Econex re-evaluated the HMI’s local concentration and admission results using the full HMI hospital sample and presented the results at the Facilities Seminar. Their results led them to conclude that the HMI results “do not hold” with the larger sample.  

![Image](source: Diagram based on results from Table 6.14 of the Provisional Report)

31. There is also no evidence presented by the HMI experts regarding any price-concentration relationship. In contrast, Netcare experts conducted a detailed empirical analysis of pricing and local concentration that is uncontested. They concluded that after controlling for funder mix, patient acuity mix, and procedure mix, there is no evidence that tariff or revenue/admission vary with concentration.

32. Accordingly, there appeared to be a high degree of consensus amongst the facilities groups’ economic experts that the local market concentration measures that have been obtained by the HMI, based on the Lavielle methodology (and/or in conjunction with the HMI’s LOCI measures) are unreliable and inconsistent.

33. Accordingly, any conclusions which the HMI seeks to draw from the analysis using the Lavielle methodology or its local concentration measures are likely to be unreliable and, therefore, no meaningful conclusions can be drawn from such analyses for the purpose

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42 Mediclinic presentation 9 April 2019 at slide 9. Econex also reported the results of the HMI experts’ analyses using broad instead of narrow disease burden, which resulted in inconsistent results.

of determining the extent of competition at a local market level.

(iii) Conclusion

34. In summary, there appears to be a significant degree of consensus that concentration levels are declining in the facilities sector and that the sector has been characterised by significant levels of new entry, particularly by independents and the NHN. This is underscored by the fact that the theory of supply induced demand put forward by the HMI, is itself predicated on the existence of an ample supply of beds in the facilities sector, which the evidence shows is largely as a result of new entry by the NHN and independent hospitals. It also appears to be reasonably well accepted that the NHN is a credible, large fourth hospital group, which funders can contract with as an alternative to Netcare, Mediclinic and Life.

35. These facts indicate that in relation to facilities there are sufficient competitive alternatives for funders to engage with and that there are no insurmountable barriers to entry in the facilities sector. Evidence on network alternatives and increasing use of networks is also inconsistent with significant local concentration issues. In addition, market conditions are conducive to effective bargaining by funders, particularly as has been demonstrated through the establishment of networks, which have proven to be particularly successful in reducing costs and enabling funders to play off one hospital group against another. A key theme that emerged from the facilities concentration seminar in this regard, was the importance of “volume” to the hospital groups in competitive bargaining and that being excluded in whole or in part (or threatened with exclusion) from a network could have very serious implications for a hospital group from a financial perspective.

36. It was also pointed out that being excluded from a network, not only had immediate negative financial implications for the hospital group concerned, but may also have negative consequences for doctors that practise at the hospital concerned, because they may lose a significant number of their patients, if those patients are required to make co-payments at the hospital concerned. If the hospital loses a scheme which is an important contributor to a specific doctor, the doctor in question may cease practising at the hospital and start practise at another hospital which is contracted to the relevant scheme. This means that even if the scheme is a relatively small contributor to the hospital overall, its
loss may result in the hospital losing 100% of the revenue of certain doctors (including that associated with patients who are not members of the scheme in question). This is a significant incentive for facilities to seek to be included in scheme network options and to provide competitive pricing and services.

37. In conclusion, following the concentration seminar and the stakeholder submissions on the sections dealing with concentration on the provisional report, in light of the factual evidence that the national facilities market is not highly concentrated and the local market analysis is fundamentally flawed, the HMI needs to reconsider its provisional findings that the national and local markets for facilities are highly concentrated. Most importantly, as emphasised in Netcare’s submissions in respect of the provisional report and as re-iterated during the seminar, not only are the national and local facilities market/s not highly concentrated, but there is no credible theory of competition harm flowing from the concentration analysis, whether in the form of excessive pricing or some other form of abuse of market power, which would warrant the imposition of remedies on the facilities.

44 We address these points on theories of harm and lack of evidence further in the remedies section.
C. FUNDER CONCENTRATION

Introduction

38. In assessing concentration levels in the funder market the HMI found in its Provisional Report that “[t]here has been consolidation in the medical scheme market since 2000 when the MSA came into effect. The total number of medical schemes decreased from 163 in 2000 (consisting of 47 open, 97 restricted and 19 exempted medical schemes) to 82 (consisting of 22 open and 60 restricted) in 2016. There have also been very few new medical scheme entrants that are still in existence today.”45 (Our emphasis)

39. When considering the open and closed medical scheme markets respectively, the HMI found that “the HHI has increased steadily for both open and restricted medical schemes for the period 2005 to 2016. In 2016 the top two medical schemes, DHMS and Bonitas constituted 70% of the total market. Based on these calculations, the open medical scheme market has been highly concentrated (recording an HHI >2500) for the last six years.”46 (Our emphasis)

40. According to the HMI, GEMS is dominant in respect of restricted medical schemes with a market share of 47%, while Discovery Health Medical Scheme is dominant in respect of open medical schemes with a market share of approximately 55%.48 Discovery recently indicated during the seminars convened by the HMI that its market share in the open scheme market is close to 56%.49

41. Turning to the medical scheme administrator market, the HMI found that “[a]s with the medical schemes market, the HMI has observed high market shares for some administrators and high concentration levels for the medical schemes administrator market.”50

42. The HMI also noted concerns, which had been expressed in relation to the lack of sustainable entry at both a scheme and administrator level, as well as the observed persistent and increasing concentration levels. In this regard, the HMI articulated its

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45 See the Provisional Report page 80, paragraph 22.
46 See the Provisional Report page 83, paragraph 33.
47 See the Provisional Report page 82 at Table 5.2
48 See the Provisional Report page 80 and 82.
49 Competition Commission Health Market Inquiry: Session 1 of 10 April 2019 at page 7.
50 See the Provisional Report page 136, paragraph 344
concerns as follows:

“By creating and reinforcing the market power of large firms, barriers to entry tend to lead to higher prices, lower levels of innovation and a less competitive market. They may thus prevent a medical scheme administrator from competing and expanding in a way that will improve the overall value of the product offering to its contracted medical scheme and consumer.”

43. In its subsequent note on funder concentration and remedies, which the HMI published on 2 April 2019, the HMI, however, appeared to shift its stance that the high level of concentration at the funder level, was of a nature that warranted serious concern. This approach does not appear to be consistent with the approach which it adopted in respect of remedies in relation to the facilities sector. In this regard, the HMI noted that “concentration in the funders market can be divided into its effects on what the provisional report called the downstream market, when providing coverage and services to beneficiaries, and in the upstream market, when procuring services e.g. from practitioners and facilities.”

44. By making this distinction the HMI then sought to suggest that a lack of “structural remedies” at a funder level was appropriate as the “difference in remedies reflects the view that competition authorities the world over are less concerned with concentration which results in buyer power” (Our emphasis). This statement however focuses only on one aspect of funder concentration – and does not address the downstream side i.e. the relationships between schemes and members and indirectly administrators and members.

Netcare’s perspective on the HMI’s analysis – funder concentration

45. On 10 April 2019, the HMI held a seminar on both funder concentration and countervailing power vis-à-vis funders and facilities. In this section we deal principally with funder concentration. The topic of bargaining power will be addressed in the subsequent section.

51 See the Provisional Report page 136, paragraph 344
52 Seminar Note: Overview of HMI Funders’ market concentration and remedies. Published on 2nd April 2019, page 2.
53 Seminar Note: Overview of HMI Funders’ market concentration and remedies. Published on 2nd April 2019, page 7.
54 Seminar Note: Overview of HMI Funders’ market concentration and remedies. Published on 2nd April 2019, page 7.
following section of the paper.

46. During the seminar, the HMI panel heard presentations from Stan Eiser, GEMS, Discovery, the Council for Medical Schemes (“CMS”), PPO Serve, MMI and Netcare.

47. Of the seven stakeholders which made submissions on 10 April 2019, only two stakeholders, the CMS and Netcare, attempted to analyse concentration at the funder level. Unfortunately, the CMS did not appear to follow the standard application in competition economics of the Herfindahl-Hirschman Index (HHI) and as such the results of its analysis cannot be relied upon.

48. Netcare’s experts noted in their submission to the HMI that there had been a “[t]rend of increasing concentration (HHI)” at a funder level which was “due to increased shares of the two largest [administrator] firms (from 45% to 77%) and a decline in all other administrators to 19%.”55 In addition, it was also pointed out that Discovery Health (the administration business) indicated in its most recent annual report that its market share is now well over 40%, suggesting an even higher HHI today.56

49. When considering the trends in HHI’s at a funder level, it is evident that the HHI levels have more than doubled since 2005, with very limited entry having taken place. This is the case in relation to the administrator market, the open medical schemes market and the closed medical scheme market. Netcare’s experts noted that “[i]n 2005, HHIs in the administrator and closed scheme markets were below 1500 (non-concentrated) and the open schemes HHI was just above 1500.”57 However, it was pointed out that by 2016 “HHI’s in [the] administrator and open [scheme markets] were both above 3000 (highly concentrated), and the closed scheme HHI increased substantially to 2422.”58 The HHI trend at a funder level is depicted in more detail below:

55 Seminar: Funders’ Market Concentration and Countervailing Power: Margaret E. Calvert and Jeremy Nighohossian, Ph.D., 10 April 2019 at page 6. In the HMI’s Provisional Report at page 133, paragraph 340 the HMI notes for 2016 that “Table 5.5 illustrates that the administrator market is highly concentrated with two administrators, Discovery Health and Medscheme, accounting for 76.1% of the market (based on GCI).”

56 Discovery Health notes at page 31 of its 2018 Annual Report that its market share increased to 44%. See https://www.discovery.co.za/assets/discoverycoza/corporate/investor-relations/iar2018/discovery-iar2018.pdf


50. It is important to note that none of the other stakeholders appeared to fundamentally disagree with the view that the various funder markets are highly concentrated. Despite several funders making submissions to the HMI during the funder concentration seminar, none disputed the fact that the various funder markets had become very highly concentrated. This was highlighted when the Panel questioned Discovery Health about the high and increasing levels of concentration at a funder level:

**Dr Bhengu:** “But I suppose the point I was making is that I thought I heard Dr Bloomberg referring to market share, I think maybe he was just making an example fifty sixty or whatever. And I suppose the issue was trying to marry this with the page sixteen table which roughly just shows a negative if one looks at joiners versus leavers. So, I was trying to marry that with a market share that has grown, but the table you are giving us shows the other way. Those figures for 2018 don’t even match the front-page figures for 2018.

This is important because it’s about a question that we asked very early in public hearings. In trying to get to the power balance between funders and hospitals in particular. And I recall all three hospitals and Discovery basically saying it’s evenly balanced.

Now, I'm not sure that's where we are now. Because when I look at this state of the enquiry when one looks at the actual hard figures, when we look regarding
market shares, hospitals we are fighting but we are talking about 25% market share. And when one looks at GEMS, Discovery, the scheme, we are looking at fifty-five forty-seven. So, the highish market share are on the funder side. As I am sure now it's about 40% or so on the administrator side, and Medscheme also should have gone up. Which also speaks to the higher entry barriers because we did say we are not seeing new entry for whatever reason on the administrator side.

On the HHIs again we are fighting whether its 2 501 or 2 499 going down on the funder side, we are talking 3 000 going up. And profitability, the only excessive profitability that we are referring to comes from the funder side....

When one looks at data clearly funders have got a more complete view as opposed to all other service providers who really only see their own data from that regard.

Now, I also look at the fact that schemes do choose not to use providers that are available and willing, but I don't think the reverse applies. The bottom line what am I saying. What I am saying is we are at the stage where the question of power balance we need to consolidate the figures and what I personally am seeing is it very clearly seems to be that the funders have the better end of the stick. I don't know if there is any comment, or any funder wants to make because it's one of the most critical questions we set out to answer as the enquiry.”

51. It also appears to be widely accepted that there has been little in the way of new entry in the highly concentrated funders’ markets. This clearly has implications not only as to the degree to which there is competition between schemes, as well as competition between administrators, but is also indicative of the fact that there are large and well-resourced funder organisations, which is relevant when it comes to assessing buyer power on the part of schemes and administrators, as well as competition in the downstream market for consumers. It should also be noted that in many instances, administrators negotiate on behalf of schemes, which benefit from the bargaining and purchasing power of the administrators. Discovery, for example, negotiates on behalf of 17 closed schemes as well as the Discovery Health open medical scheme.

59 Competition Commission Health Market Inquiry Seminar: Session 3 of 10 April 2019 at page 74
D. BARGAINING POWER AND COMPETITION

Introduction

52. As indicated in the preceding section, bargaining outcomes between funders and facilities depend on the availability of the outside options available to both parties. In particular, schemes such as Discovery Health Medical Scheme and GEMS, which represent over 55% of beneficiaries, have a significant degree of bargaining power and in general, large negotiators (Discovery Health and GEMS) are able to negotiate very competitive tariffs. As was noted in the submissions and in the seminars, the evidence also demonstrates that smaller funders are also able to negotiate competitive tariffs.

53. In addition, the HMI confirms that the successful implementation of networks by funders (both large and small) provides an important source of evidence that there is countervailing power against hospital groups for both large and small funders and has resulted in lower prices for schemes. These networks make use of the availability of sufficient hospital alternatives (outside options) for funders, and have been implemented by smaller funders as well.

54. However, despite these incontrovertible facts, the HMI has made a number of questionable statements in its Provisional Report, where it appears to question the degree to which funders are efficient negotiators, as well as the ability of funders to curtail price increases by facilities. This focuses on concerns about facility market power, which as shown in the previous section are unsupported either by concentration or pricing evidence. The HMI makes findings that the three large facilities groups are a “must have”60, even for funders such as Discovery. The HMI also finds that “hospitals would be able to increase prices substantially”61, because “demand for their services is generally inelastic”62.

55. In its supplementary note on facilities concentration of 2 April 2019, the HMI reiterated this position when it noted that “These hospital groups, to a significant degree, are a must-have. Medscheme, for an example, must necessarily contract with each of Life, Mediclinic and Netcare. This dynamic provides the three hospital groups, both

60 See the Provisional Report at page 185, paragraph 121.
61 See the Provisional Report at page 220, paragraph 280.1.
62 See the Provisional Report at page 220, paragraph 280.1.
individually and collectively, with a significant degree of bargaining power.”63 (Our emphasis)

Netcare and other stakeholder perspectives on countervailing power

56. While the HMI acknowledges the theoretical underpinning of economic bargaining theory, which postulates that a market player’s bargaining position will to a large degree be informed by the existence (or lack thereof) of sufficient outside options, it clearly ignores the very important distinction that while there are sufficient facilities to provide several close substitutes from the perspective of funders, there are significantly fewer options from the perspective of facilities.64

57. This important distinction highlights the fact that while funders have a sufficient number of alternatives and the ability to choose among facilities and provide competitive offerings to their beneficiaries, facilities have significantly fewer alternatives, and seek to have as many funders, particularly the large ones, as possible in the interests of securing patients for their facilities.

58. When the levels of concentration in the facilities market is considered (the fact that these markets have become increasingly less concentrated and where there has been considerable new entry), compared to the funders market, which has become increasingly concentrated over the same period, it becomes evident that the number of outside options available to funders has increased (through the emergence of NHN as a fourth network and a strong fringe of independents), while the number of funders available to hospitals has decreased. This is a simple way of demonstrating that the number of outside bargaining options available to funders have increased, while over the same period the number of outside options available to facilities has decreased.

59. Thus, at a principled level, the facts illustrating consistently decreasing concentration in the facilities market, allied with consistently increasing concentration in the funder market, is not consistent with a finding that certain hospital groups are “must haves” or that they “have the whip hand” in bargaining with the schemes / administrators. Thus, we encourage the HMI to re-consider both its structural assessment and its bargaining

63 See paragraph 14 of Seminar note on facility concentration dated 2 April 2019.
64 See also Facilities’ Market Concentration: Comments on Proposed Remedies. Richard Murgatroyd, 9 April 2019 at page 8
assessment.

60. During the hearings in the healthcare market inquiry, Dr Broomberg, the CEO of Discovery Health, indicated during the HMI public hearings that he believes that “Discovery Health does have countervailing power on behalf of the eighteen medical schemes that we negotiate with a mandate for”\(^6^5\).

61. In addition, Dr Broomberg noted that the main sources of Discovery Health’s bargaining power included “very sophisticated risk analytics”\(^6^6\) which enabled Discovery Health “to deeply understand the costs and what is driving them across all hospital groups”\(^6^7\), as well as the important role which networks play in affording Discovery Health bargaining power:

“network plans give significant bargaining power because hospitals compete on price to be included in those network plans and today if you look at Discovery Health medical scheme, roughly 30% of all the membership are in a network plan and so there is certainly some bargaining power in relation to participation in the network plans”

and

“[Keycare has] four hundred and fifteen thousand members and it can be a big impact on a hospital group if it gets moved out of that network and that gives our negotiating team tremendous bargaining power”\(^6^8\) (Our emphasis)

62. Moreover, Dr Ryan Noach, the deputy CEO of Discovery Health noted in an interview with JP Morgan on 5 April 2017 that Discovery was implementing a system of installing on-site case managers in certain hospitals. He also noted that there was in his view


“balanced market power in the negotiations between hospitals and Discovery in South Africa”. Furthermore, during the recent HMI seminars, Emile Stipp on behalf of Discovery indicated that, “And I think an important thing there, what we are saying is the players generally agree, and we agree with that, that there is counter-veiling power.”

Large hospital groups do not enjoy must-have status and funders are able to use networks effectively to exclude providers

63. Contrary to the views expressed by the HMI that hospital groups enjoy “must-have” status, the evidence of several funders and facility groups undermines the contention that hospital groups enjoy “must-have” status. There are a number of examples where schemes have excluded one or sometimes two of the three large hospital groups from networks.

64. Netcare’s experts presented further evidence which showed “Many network examples of exclusion of hospital groups or specific hospitals”. For example, in 2019 the following networks were illustrative of instances, where either one or more hospital groups were excluded entirely and/or there had been exclusion of specific hospitals on a selective basis by schemes and administrators:

“Health Squared Medical Scheme: Life Health excluded.

Medshield DSP – Network: Mediclinic generally excluded.

Selfmed DSP: DSP Option reinstated with Netcare; LifeHealth excluded.

Medipos DSP – Hospital Network: All Netcare facilities excluded from DSP; all scheme options for 2019.

Umvuzo EDO/Filler Hospital: All Netcare facilities excluded - new EDO Ultra Affordable Option & DSP Proposal for Activator Option.

Fedhealth EDO “Elect” Option – Hospital Network: All Netcare facilities excluded

69 Competition Commission Health Market Inquiry Seminar: Session 3 of 10 April 2019. See Transcript at page 75.

70 Seminar: Facilities’ Market Concentration and Remedies: Margaret E. Calvert and Jeremy Nighohossian, Ph.D., 9 April 2019 at page 12.
from new very limited EDO which has Government, Lifehealth, Mediclinic and NHN hospitals except for Ceres Hospital.

**GEMS – Emerald EDO Option:** Value Option (EVO). Netcare and Life Health plus 10 NHN hospitals. **Mediclinic** excluded from the EVO.

**Polmed DSP – Filler Hospital:** Netcare excluded as anchor DSP status for scheme; 17 Netcare facilities added as filler sites. 14 Same Day facilities; 11 Psychiatric Facilities.

**Profmed Savvy EDO – Filler Hospital:** Mediclinic and Life Health as anchor network. 16 Netcare as fillers (16 acute; 12 psych; 15 same day facilities).

**Keyhealth DSP – Options awarded to Netcare as anchor:** Equilibrium, Essence Silver, Netcare and Life Health were awarded the DSP contract. **Mediclinic and NHN** excluded with exception of specific regions.

**Bonitas – DSP Network:** DSP Network inclusive of all Netcare hospitals for options which do not have own EDO network. **Excludes 14 Life Health facilities** in major metro areas.

**Fedhealth EDO Options – Netcare as anchor:** Benefit Options Included. **Mediclinic, LifeHealth** excluded with exception of some specific regions”

65. This position was also confirmed by Mediclinic, whose experts noted that, “The three large hospitals groups are not must-haves, as there are currently networks without their hospitals” and “The economics is clear-networks are pro-competitive and put downward pressure on costs” (Our emphasis)

66. On the HMI’s own analysis in relation to industry-specific data on networks, its conclusions were very instructive, providing evidence of a competitive market where providers are discounting significantly in competing for the right to be included in access networks:

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71 Seminar: Facilities’ Market Concentration and Remedies: Margaret E. Calvert and Jeremy Nighohossian, Ph.D., 9 April 2019 at page 12
“the results confirm that the introduction of network options has resulted in increased funder bargaining power during negotiations which has resulted in lower tariffs for these options. This appears to have been an important development in the market from a tariff perspective and has resulted in increased competition among hospital groups.”73 (emphasis added)

67. Netcare’s own experience on networks, as reflected in its response to the HMI’s Provisional Report, shows that networks have grown significantly in the last few years.

68. Significant consensus on this point was also established during the seminar, directly contradicting the conclusion drawn by the HMI that the three large hospital groups are “must have” hospital groups.

69. Life Healthcare’s experts also confirmed that the existence of so-called “solus” sites provided little to no leverage for hospital groups as “Funders can (and do) break up their DSPs to prevent private hospital groups from leveraging solus facilities into broader negotiations”, that “Certain funders have completely excluded LHC from their DSP networks (e.g. Bankmed and Medihelp Necesse) despite LHC possessing 7 solus facilities (as per the PFs)” and that “Funders have also partially excluded LHC from their DSP networks (e.g. Bonitas removed 14 LHC hospitals from its DSP network)”74. Indeed, Life Healthcare was candid in acknowledging that networks accounted for up to 50% of its overall revenue. This is depicted in the figure below:

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73 See the Provisional Report on page 222, paragraph 298.
Source: Life Healthcare presentation slide 6

70. For their part, several medical schemes and administrators confirmed the importance of networks and the bargaining power they conferred on funders in negotiations with providers. For example:

70.1. Medscheme noted in its presentation that “CMS allowed EDOs [Efficiency Discount Options] – trustees [are] more willing to establish networks.”

In addition, Medscheme noted during the course of its presentation that, “from a network perspective as the NHN growth has created additional competition it is an alternative network” and that in the future “we are going to see over time more and more networks implemented”.

70.2. Discovery Health noted that networks are “Useful tool – providers willing to commit to requirements – quality, cost and access” and that “DSPs / Networks play important role in countervailing power and promoting quality of care through contracting requirements” as well as that the “Network approach [is] appropriate for managing quality and driving cost efficiency.”

Furthermore, in highlighting the effectiveness

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75 HMI Seminar: Facilities Market Concentration and Remedies: Dr Jenni Noble, 9th April 2019, at page 12.
78 Workshop 1: Facilities market concentration and remedies, 9th April 2019, at page 16.
79 Workshop 1: Facilities market concentration and remedies, 9th April 2019, at page 18.
80 Workshop 1: Facilities market concentration and remedies, 9th April 2019, at page 19.
of Networks Dr Paleng from Discovery noted that “you need at least two players to commit to participation and what happens over time, even if you have some reluctance from one of the groups to participate, over time they do come to the party because the selection effect plays out and through loss of revenue and loss of market share there the third player or fourth player will come and make a proposition to participate.”81 (Our emphasis)

70.3. GEMS in its presentation which was submitted to the HMI also noted that “A designated service provider network must simultaneously reduce the cost of care, improve healthcare outcomes and facilitate empowerment.”82

71. Furthermore, the ability of funders to influence the investment decisions of hospital groups was also highlighted during the seminars which were held by the HMI. For example, Netcare noted that it ceased the development of a new hospital facility in Pretoria, as it could not obtain a commitment from funders that they would support the facility once it had been built.

“from the Netcare stable in February last year when a mental health facility was opened in Pretoria and it was not listed by Discovery on any of its schemes so not a network, it’s not about a network plan across the board, there is an aggressive co-payment if you use that facility so that is an Akeso Arcadia facility if you want to know the exact name. We know of one in KZN which is independent, that hasn’t been listed and maybe you want to talk to that and we can tell you that Netcare has canned a project in Pretoria … because of indications that it would not be listed.”83 (our emphasis)

72. This was confirmed by Discovery who noted that “So, certainly, the example that has been given is true; Netcare has no reason to make things up.”84 The ability of funders to withhold support for new hospitals was also a key component highlighted by Medscheme which noted during its presentation that “what we are doing as funders is trying to manage the issue of supply induced demand on our own by basically saying we

82 Market Concentration and Countervailing Power, April 2019 at page 24
83 Competition Commission Health Market Inquiry Seminar: Session 3 of 9 April 2019, transcript at page 28
84 Competition Commission Health Market Inquiry Seminar: Session 3 of 10 April 2019, transcript at page 16
Schemes view ARMs as an important tool for driving efficiency at a provider level

73. The HMI’s views that existing Alternative Reimbursement Models (“ARMs”) between funders and hospitals are insufficient and, at times, even inefficient are not well founded and at times contradictory. For example, in concluding that ARMs currently have a “limited bearing on tariff negotiations,” NMG which performed the analysis on behalf of the HMI, admits that the data it relied on is incomplete and lacks sufficient detail to produce reliable results. The HMI seems to believe that the efficiency benefits associated with ARMs would outweigh the costs of having hospital groups bear additional risk, but provides no analysis to support this conclusion.

74. Indeed, despite agreeing that “[t]he South African healthcare market has generally been exhibiting a trend towards a greater acceptance and implementation of ARMs”, the HMI exhibits a degree of concern, which is not substantiated by way of any substantive analysis, when it concludes for example that “[t]he ARMs that are currently in the market have predominantly been initiated by hospital groups. This questions the credibility of the countervailing power of funders as ideally, from a consumer perspective, they would be the ones designing and proposing such reimbursement mechanisms for the benefit of their members.”

75. Such assertions are not only inconsistent with the HMI’s own statements, but are also not supported by the evidence which is available to the HMI. In fact, the HMI did not perform any robust statistical analysis to arrive at its conclusion that funders are unable to exercise “sufficient” bargaining power over hospital groups. This is fatal to the conclusions sought to be drawn. Conclusions unsupported by proper evidence and robust analysis cannot be relied upon.

76. Indeed, the recent submissions by Discovery Health during the seminar noted the importance of ARMs when they stated in their presentation that “[s]elective contracting

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85 Competition Commission Health Market Inquiry Seminar: Session 3 of 9 April 2019, transcript at page 11
86 See the Provisional Report on page 222 at paragraph 303.
87 Cornerstone Research Report, paragraph 7(a)(i), page 4.
88 See the Provisional Report on page 52 at paragraph 100.
89 See the Provisional Report on page 222 at paragraph 301.
required for Alternative Reimbursement Mechanisms (ARMs) to deliver value effectively\(^{90}\) and that it was urgent to remove the “regulatory barriers to ARMs and network design, including removal of HPCSA rules”\(^{91}\). This suggests factors other than market power or bargaining power represent constraints on increased use of ARMs, including rules that may inhibit shifts to more integrated care.

77. In addition, Medscheme also noted that schemes and administrators were able to drive efficiency amongst providers, on the basis that if specific hospitals were deemed by the scheme (or administrator) to be inefficient, they would be removed from the network:

> “The other thing that is important is cost inefficiency, even of an anchor hospital within that network that hospital can get taken off because we don’t want inefficient facilities on that so I think the important thing is, from a network perspective we can call the shots and that is the massive advantage of a network”.\(^{92}\)

78. In summary, there is significant documentary and empirical evidence, including the HMI’s own analysis, as well as a large degree of consensus amongst various stakeholder submissions, that funders are able effectively to make use of alternative facilities and also that they are able to leverage their network options to negotiate lower tariffs for their non-network options.\(^{93}\) Based on Netcare’s submissions and the submissions of other stakeholders, funders that operate network options are also able to negotiate lower tariff increases for their non-network options.\(^{94}\)

79. In summary, the totality of the evidence supports the conclusion that funders have, and do exercise, significant countervailing power in negotiations with providers, including the large hospital groups.

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\(^{90}\) Workshop 2: Funders’ market concentration and countervailing power dated 10th April 2019 at page 19

\(^{91}\) Workshop 2: Funders’ market concentration and countervailing power dated 10th April 2019 at page 19

\(^{92}\) Competition Commission Health Market Inquiry Seminar: Session 3 of 9 April 2019, transcript at page 27

\(^{93}\) Cornerstone Research report, Section titled “Contrary to the HMI’s claim, there is evidence that schemes leverage their network options to negotiate lower tariffs for their non-network options” page 29.

\(^{94}\) See also Cornerstone Research report, Table 1, page 32.
E. SUPPLIER INDUCED DEMAND

Introduction

80. The Provisional Report presented a new theory of the alleged link between the expansion of health care supply (in particular that of hospital beds) and the alleged increase in utilisation of healthcare facilities and services, which the HMI has termed as the theory of “Supplier Induced Demand”. This analysis and the underlying methodology in relation to the theory, appeared for the first time in the Provisional Report.

81. The Provisional Report concludes: “In summary, on the basis of a logistic regression analysis of the medical schemes dataset from 2010 to 2014, there is sufficient evidence to confirm that rates of hospital admission are positively associated with levels of supply of both doctors and hospital beds, after adjusting for clinical and demographic factors. While this does not imply intentional misrepresentation by either doctors or hospitals, it does suggest that supply-induced demand exists in areas where there is discretion around whether or not to admit a patient.”95 (our emphasis)

82. The Provisional Report asserts that supply induced demand is the source of excess utilisation and that this is driven by unregulated entry and expansion. The theory advanced by the HMI is premised on the supposition that supply induced demand increases as the market becomes less concentrated.

83. In its seminar discussion note of 4 April 2019, the HMI provides its first clear articulation of a definition of what it means when it refers to supplier induced demand. The HMI defines supplier induced demand as “the provision of services without a commensurate improvement in health outcomes”. It should be noted that this definition is expansive and would include activity beyond the straightforward interpretation that Supplier Induced Demand is the provision of unnecessary services which is encouraged by physicians or other providers.

84. Dr Sonderlund also indicated during the seminar that “The hypotheses being that doctors and hospitals may be able to induce greater demand for their services where they had excess capacity or capability to deliver and that was driving up overall utilisation

95 Provisional Report Chapter 8, paragraph 55.
rates”. However, as Dr Soderlund subsequently conceded the regression model which he had used could not test or demonstrate that hospitals induced greater demand for their services.

Netcare and other stakeholder perspectives on alleged excess utilisation and so-called “supplier induced demand”.

85. The seminar presentations (and related submissions) on so-called Supplier Induced Demand appear to confirm there is no sound economic or empirical basis for the theory of Supplier Induced Demand for private healthcare in South Africa as it relates to hospitals.

86. Several fundamental concessions were made by the HMI’s own expert during the seminar on 12 April 2019 and confirmed the views of a number of experts about the lack of any probative evidence for the HMI’s theory of Supplier Induced Demand. The seminar presentations also provided an extensive critique of the Supplier Induced Demand regression modelling without any effective rebuttal; which calls into question the reliability, admissibility and usefulness of the HMI’s analyses for evaluating any potential theories of Supplier Induced Demand.

87. It is now clear that the term “Supplier Induced Demand” has been used very loosely by the HMI’s advisers and certain schemes and administrators to encompass general increases in utilisation and admissions at hospitals, rather than more precise definitions that focus only on “excess” or unnecessary utilisation caused by bed or physician increases. These loose and general definitions are different from – yet often confused in the papers - with the specific Supplier Induced Demand theory of unnecessary or excessive utilisation caused by the addition of new beds (hospitals) or by the behaviours of admitting physicians as they increase in number. The lack of precision in defining Supplier Induced Demand, means that much of the “evidence” before the HMI is simply anecdotal information or data on increased admissions or purported excess bed capacity. Such “evidence” cannot be used to support Supplier Induced Demand theories. Moreover, Dr Soderlund’s analysis often makes the same mistake by examining

96 Transcript, page 5.
97 This clarification admits that higher levels of utilisation or of specific admission types may reflect some deviation from expectations or averages, but that factors other than Supplier Induced Demand theories are drivers of such levels.
admissions, rather than unnecessary admissions and not making the necessary causal linkages.

88. While the HMI belatedly attempts to define Supplier Induced Demand as “provision of services without a commensurate improvement in outcomes”, it does not test this definition by way of any analysis, ostensibly, because “these [outcome indicators] are not available in South Africa.” Moreover, the vast majority of stakeholders that presented on the topic appear to agree that Dr Soderlund’s regression model analysis only considers admissions (not avoidable or unnecessary ones), and that increased admissions may be an effect rather than symptomatic of a cause.

89. In his presentation at the seminar Dr Soderlund unequivocally conceded that the regression model cannot demonstrate that:

“hospitals can or do directly influence patients to undergo treatment”;

“hospitals systematically influence doctors to over service patients using their facilities”;

“there is any relationship between competition / market concentration and Supplier Induced demand

•No data on market concentration were used in the model

•Oversupply could drive excess if there is one supplier of those services or ten of them – the incentives are exactly the same”

90. These concessions clearly indicate that Dr Soderlund’s regression model cannot be used to make any claims that hospitals influence demand for their services, either in respect of patients or doctors.

91. The HMI has asked stakeholders to identify areas of consensus. One of the areas of consensus, given Dr Soderlund’s concessions, from an expert economic perspective, would be that there is no basis for giving any credence to the Supplier Induced Demand theory as currently articulated in the Provisional Report. Our detailed reasons for this view are set out more fully below. In addition, the stakeholders offering opinions on the

98 Dr Soderlund presentation entitled “Supplier-induced demand: Introduction and brief response to submissions” at slide 5.
specific analyses performed by the HMI’s experts with regard to Supplier Induced Demand, agree that those analyses were problematic. No independent stakeholder confirmed or defended the specific work conducted by the HMI’s experts in this regard.

92. **First, the almost universal consensus about causation, conclusively rejects a Supplier Induced Demand theory of harm:** There appears to be clear consensus, including the HMI’s own expert, that none of the Supplier Induced Demand analyses prove that an increase in hospital beds led directly to an increase in admissions. Nor do these analyses based on the regression model support any inference that hospitals have the incentive or the ability to drive excessive or unnecessary utilisation.

92.1. As Dr Soderlund affirmatively states: “*This [analysis] doesn’t prove causation – it shows [only] an association that a decision-maker needs to interpret.*” Neither Dr Soderlund’s regression analyses (by its author’s own admission), nor any analyses submitted by third parties (for example those of Discovery Health) demonstrate that an increase in beds **causes excessive** increases in admissions or unnecessary utilisation.

92.2. The inability to demonstrate a causal link between the addition of beds (supply) and admissions (or excess admissions) – in and of itself – is a sufficient and compelling basis for rejecting the Supplier Induced Demand theory of harm and the need for any remedial intervention. A Supplier Induced Demand theory of harm requires that additional beds or entry cause unnecessary or excessive utilisation. It cannot be left open to “interpretation” as Dr Soderlund appears to assert.

92.3. Lack of causation means that any analysis showing some ‘association’ between added beds and increased admissions could as likely mean the reverse – e.g., that the addition of beds were to meet expected demand. It could also be that new beds were the result of increased entry by hospital groups such as NHN seeking to expand their network of facilities, or were the result of entry by independent hospitals seeking to meet specific demands in local areas. Each of these explanations – responsive new entry

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99 This statement is made with regard to “interpreting regression analysis results” and the relationship between “someone’s chance of being admitted to hospital” and additional beds. Slide 4, Supplier Induced Demand, Introduction and brief response to submissions. Economic experts from various stakeholders concur that the analysis has not demonstrated that increased physicians or hospital beds lead to increased utilisation or inappropriate levels of utilisation, nor does it claim it does. Experts and submissions for Life Healthcare, Mediclinic, and Discovery point this out.
by competitors that enhance competition in the marketplace and responsive new entry to meet expected demand of (newly insured) residents, are plausible and realistic drivers of the observed bed additions in South Africa. These are benign and pro-competitive – not Supplier Induced Demand as suggested by the HMI.

92.4. We strongly encourage the HMI in its final findings and recommendations to take note of this virtually unanimous consensus that the analyses performed by Dr Soderlund do not demonstrate causation – and given the importance of causation to any Supplier Induced Demand theory of harm, the lack of causation also means there is no basis for the proposed significant regulatory interventions suggested by the HMI, which are predicated on a theory of Supplier Induced Demand. **While failing to demonstrate causation is a standalone basis for rejecting any reliance on theories of Supplier Induced Demand set out in the Provisional Report and elsewhere, there are numerous other bases to reject the Supplier Induced Demand theory advanced by the HMI. These are addressed below.**

93. **Second there is consensus against hospital-based theories of Supplier Induced Demand and also a lack of evidence of any hospital driven Supplier Induced Demand:** The HMI’s expert, Dr Soderlund, expressly made several key concessions about the Supplier Induced Demand theory as it pertains to hospitals, when he acknowledged that it cannot be concluded with confidence from the analysis or evidence that: (1) hospitals can or do directly influence patients to undergo treatment; (2) hospitals systematically influence doctors to over-service patients using their facilities; or (3) there is any relationship between competition/market concentration and Supplier Induced Demand.  

93.1. As noted by virtually all stakeholders and by the HMI, the theory of Supplier Induced Demand is essentially predicated on physician-centric behaviour, particularly in the academic literature on the topic. The preliminary study of Supplier Induced Demand

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100 Dr Soderlund states that no data on market concentration were used in the model; and that incentives for oversupply are not related to number of competitors). Slide 5, Supplier-induced demand, Introduction and brief response to submissions.

Even stronger support for the lack of any systematic relationship between concentration and utilisation was presented in econometric analyses by Econex summarised in the seminar: “Econex recalculated (based on all regions) – the local concentration results (admissions) do not hold once all regions are included.” There was consensus on this point from other stakeholder experts (e.g., Compass Lexecon presentation, 12 April 2019; and analyses in Compass Lexecon response to PR.
conducted by the HMI in 2015 found: “In our search, the literature defined supplier induced demand strictly as it relates to physicians and the servicing of patients.” “We identified nothing as applied to facilities and suppliers.”

93.2. With regard to physician theories, the HMI speculates that physicians unnecessarily refer patients to hospitals for their own financial gain – effectively asserting “conscious or unconscious” unethical behaviour. However, the HMI has not presented compelling, comprehensive evidence to support a contention that physicians have engaged in a widespread practice of unnecessary admissions or over-servicing. No basis has been provided for the suggestion that hospital expansions in and of themselves increase physicians’ incentives to increase unnecessary admissions.

94. **Third, there is consensus that many factors drive utilisation and that many are benign.** The anecdotal and other data show utilisation trends are explained by other factors. Using the broad disease burden, which most parties consider to be more appropriate for evaluating admissions, explains almost all of the increase in admissions. While it is asserted by Dr Soderlund that the broad burden of disease metric cannot be relied upon, because it uses data from the actual admissions concerned, this assumes either that the relevant hospital’s coding of a patient’s diagnosis is systematically overstated, or that there is no additional information about the diagnosis (heart attack) that brings the patient to the hospital (as distinct from information derived from non-hospital sources). These assumptions are purely speculative and have not been borne out by any analysis of the data. Furthermore, funders routinely reject accounts from hospitals that they believe are not appropriately coded by hospitals and periodically engage in coding audits of various hospitals.

94.1. The reasons underlying admissions and increases in admissions is the key question that needs to be resolved before undertaking the type of Supplier Induced Demand analysis conducted. Understanding whether the admissions are necessary or unnecessary is essential before regulators consider adding new restrictions that would serve to reduce those admissions. **Without knowing the cause of the admissions, attempting to reduce them would run a great risk of reducing access to and**
utilisation of beneficial medical services. Yet there has been a complete (and, with respect, fatal) failure to assess and analyse whether the admissions were necessary or unnecessary.

95. **Fourth, third party analyses do not support Supplier Induced Demand theories of harm for hospitals or otherwise.** Discovery, Medscheme and GEMS analyses purport to show Supplier Induced Demand. All relied upon proprietary data and decisively - none of them distinguish unnecessary admissions from admissions that were required or provide the level of detail or data necessary to replicate their analyses. The Discovery entry analysis, contrary to assertions, does not support Supplier Induced Demand. Of the 19 new hospitals studied, only five showed increases in medical admissions. The remaining 14 did not. The GEMS/Medscheme analyses cannot be used to show Supplier Induced Demand due to inadequate demand-side controls. Both are inferior to the already problematic HMI analysis, because they do not control for basic factors such as income that could determine demand.

95.1. By contrast Netcare’s economic experts conducted a hospital entry analysis, using HMI data on hospitals and entry of hospitals. It did not confirm the Supplier Induced Demand theories – to the contrary, it demonstrated that they were unfounded, that increases in admissions did not follow increases in bed capacity. The funders’ presentations and submissions also confirm funders have, and deploy, numerous tools to manage utilisation, including case management, pre-authorisation and managed care.

96. **Fifthly, fundamental econometric issues in relation to the regression model mean that the Supplier Induced Demand regression results are biased and unreliable**

96.1. The HMI relies heavily on Dr Soderlund’s regression analysis and his interpretation of its results for its conclusions about “excess” utilisation and the Supplier Induced Demand theory of harm. This reliance is misplaced due to fundamental biases and issues in relation to the regression analysis.

97. **Sixth, notwithstanding the small effects estimated by Dr Soderlund’s regression model, even these estimates are biased upwards for several reasons. The following points address the numerous sources of bias in the regression model, any one of which would be sufficient to cause the regression model to be rejected as unsound.**
The extent of the errors and biased estimates imply that this “paper” (Dr Soderlund’s regression model) would not be likely to be accepted for publication. More importantly, while several issues with the model cannot be addressed owing to lack of data, even in circumstances where the model was adjusted to take care of data issues (such as omitted variable bias), the results changed or disappeared entirely, showing not only these problems have measurable impacts, but also showing that the regression itself is not robust to small, reasonable changes in its specification, another disqualifying fact.

97.1. **Simultaneity** – Areas where beneficiaries are more likely to be admitted for reasons related to beneficiary preferences will require higher hospital capacity. This creates the opposite effect from what is being studied and makes any interpretation of the estimates impossible. This is the reason underlying the criticism that the observed “effect” cannot demonstrate a causal link.

97.2. **Autocorrelation** – The unexplained drivers of admission violate a statistical prerequisite, because the same municipality is treated as a different municipality for every year, any excluded factors that affect probability of an admission will be correlated across years. This violates one of the assumptions on which regressions are based and causes biased estimates. For accurate estimates, the unexplained component of each observation, must be unrelated to the unexplained component of the other observations. The specific cause of autocorrelation can be addressed by using a technique known a “clustered standard errors” which the HMI experts did not undertake.

97.3. **Omitted variable bias** – This occurs when a regression model leaves out a factor that would explain the outcome and that factor is associated with factors that are included in the model. There are several factors such as hospital and physician quality and household income that affect the probability of admission that are not included in Dr Soderlund’s model. To the extent that some of these omitted variables are consistent across time within a municipality, fixed effects for each municipality can be added to

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103 William H. Greene. *Econometric Analysis Fifth Edition*. 2003. Page 10. Assumption A4 Homoscedasticity and non-autocorrelation. Because the admission probability is related to characteristics of the municipality that are not included in the model (for example the income level, ease of access to health services, quality of hospitals and physicians) these factors are included in the unexplained component. Furthermore, because the regression includes observations from the same municipality across several years, the unexplained component for the same municipality in successive years will clearly be related.
account for them. **Addressing this issue negates the effect reported by the regression model. Adding fixed effects for municipalities caused the effect of beds on the probability of an admission to become insignificant.**  

98. **Seventh, the fundamental data issues exacerbate the biases in the Supplier Induced Demand regression**

98.1. For the beneficiaries who could not be geocoded, the HMI assigned them zero beds. This decision led to an upwardly biased estimate of the relationship of beds and admissions, overstating the degree of correlation between beds and admissions. In other words, it artificially increased the magnitude of the relationship.  

98.2. RBB tested the effect of the beneficiaries who actually resided in areas with zero beds (a separate issue from those who had no location info and were assigned zero beds.) “Correcting for this (or excluding these beneficiaries from the analysis altogether) more than halves the estimated effect of bed capacity on the likelihood of an admission.”

99. **Eighth, the Supply Induced Demand analyses should be disregarded because they are based on flawed and incomplete bed data, and interpolations to fill in gaps led to incorrect estimate of effect.** It is important to note in this regard that only the 2010 and 2014 years had actual bed data. The 2011-2013 bed data were based on synthetic numbers. For hospitals built during this period, the assumption was that the hospital has the same number of beds when opening as it did in 2014. Some entry years and affiliations are incorrect. **Interpolation** of bed data led to the use of incorrect number of beds for approximately half of the municipality-years that were interpolated.

100. Indeed, Dr Soderlund himself acknowledged “The frequent point raised is around the

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104 RBB also added fixed effects to the model and they note that, similar to our findings, the effects for beds disappeared. They also note that the estimated effect for physicians remains.

105 To understand why, imagine a beneficiary with a lower probability of admission than the average beneficiary (which was confirmed for the beneficiaries lacking municipality data). If that beneficiary is in a municipality with at least one bed, then assuming she lives in a municipality with zero beds will strengthen the estimated relationship between beds and admissions. The only way it will have no effect is if the beneficiary actually lives in a municipality with no beds. If we assume that at least one beneficiary was incorrectly assigned zero beds, then the consequential over-estimation of the relationship occurs.

106 “See Excessive Utilisation and Supplier Induced Demand: Comments on the analysis in relation to facilities and recommendations. Richard Murgatroyd, 12 April 2019 at page 8.”

107 Dr Soderlund asserts no data was available. Netcare provided all relevant bed data in 2015 for the requested period of 2010 to 2014.
nature of the data we have used and I absolutely agree that many of the data sources we used were you know, there were significant sources of error or gaps or kind of errors where we had to try to fill in gaps in those."108. (our emphasis)

101. **Using incorrect bed data biases the results.** Without the real data, it is difficult to know the precise magnitude or the direction of the bias. Simply put, it cannot be relied upon as the “best available evidence.” As an example, the interpolation method to estimate the number of beds would create a more gradual increase in beds in the data than in reality. If the probability of an admission increased gradually over the time period studied, the regression would falsely over-estimate the effect of beds on admission probability.

101.1. **Small effects:** By reporting only the sign of the coefficients and their statistical significance, the HMI and Dr Soderlund have obscured the very small magnitude of the estimated Supplier Induced Demand effects. As Netcare’s experts have demonstrated (as did Life Healthcare’s expert submission), any levels of Supplier Induced Demand estimated through the Supplier Induced Demand analysis are exceedingly small. In two municipalities, both having 50,000 beneficiaries with the same demographics and disease profile, doubling the number of beds would, according to the HMI’s results, be associated with less than 1% more total admissions.109 Even tripling bed counts (as suggested in the seminar) results in small changes. The very small magnitude of the so called effect is critical—it means there is limited practical significance of the results flowing from the regression model and certainly not of the nature to warrant regulatory intervention of the kind posited by the HMI.110

108 Transcript page 15.
109 A typical municipality with 50,000 private beneficiaries on average has 194 beds and 9,000 admissions per year. If the municipality had 10% more beds, that municipality would have only 0.00056% more admissions. Holding everything else equal, doubling the number of beds in a municipality would only increase admissions by 0.56%.
110 This point is made very clearly in Rubinfeld (2011) regarding the role of experts and expert econometric evidence in court proceedings and the implications of the practical effect (rather than just the statistical significance of the finding: “Practical significance means that the magnitude of the effect being studied is not de minimis—it is sufficiently important substantively for the court to be concerned. For example, if the average wage rate is $10.00 per hour, a wage differential between men and women of $0.10 per hour is likely to be deemed practically insignificant because the differential represents only 1% ($0.10/$10.00) of the average wage rate. That same difference could be statistically significant, however, if a sufficiently large sample of men and women was studied. The reason is that statistical significance is determined, in part, by the number of observations in the dataset.”
101.2. **Ninth, separate (specialty) models’ results undermine theory and reject Supplier Induced Demand.** The “discretionary” models were designed to show that the relationship between discretionary admissions and beds was even stronger than the overall model. In fact, they show the opposite. Almost half of the coefficients had no statistical significance. Several of the coefficients for beds showed a negative relationship. The reported results for these specialty regressions showed a statistically significant positive effect for only 3 out of 10 specialties, meaning that the specifications that should have the strongest effect, actually show less effect than the overall model. Furthermore, several of the relationships were negative. **The HMI has not explained how this variation in results fits with its Supply Induced Demand theory.** In fact, these results are evidence that the HMI’s Supply Induced Demand theory is incorrect.

102. Dr Soderlund’s response:

102.1. Of the previous list of problems, Dr Soderlund acknowledges only two potential flaws beyond those he already conceded\(^\text{111}\) being (1) the model fit is too poor to draw conclusions and (2) the quality of supply data (both doctors and hospital beds) is too poor to use. Dr Soderlund asserted: “*None of these actually suggest our answers are wrong (or biased)*” and “*Nor do they (experts) suggest practical alternatives.*”

102.2. With regard to model fit, Dr Soderlund’s response does not adequately respond to the comments by Econex that “*The other model run was one that pooled all admissions across specialties, and which indicated a poor fit (R squared of 7.96%).*”\(^\text{112}\) As the Econex economists noted – over 90% of the variation is left unexplained by the variables included in the regression.

102.3. On the second, Dr Soderlund is proceeding on the basis of an unfounded assumption that the many sources of bias identified would not affect the conclusions. The stakeholders have demonstrated the many sources of bias inherent in the model that will definitely lead to mis-estimates of the effects explored. Some of them will clearly

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\(^{111}\) No proof of causation i.e. that beds *induce* demand, there is no evidence that hospitals directly influence patients to undergo treatment, there is no evidence that hospitals systematically influence doctors to over-service patients, there is no demonstrated relationship between Supply Induced Demand and concentration.

\(^{112}\) Excessive Utilisation and Supplier Induced Demand: Presentation to Health Market Inquiry Prof. Nicola Theron, 12 April 2019, at page 5.
lead to over-estimates of effects, others will have unknown impacts on both the magnitude and the direction of the mis-estimation. The consequence, however, is that the values estimated by Dr Soderlund in the regression are definitely incorrect, and the multitude of biases have not been investigated by the HMI in a way that would allow them to conclude their impact. Assuming, without having fully explored the various methodological issues that have been identified, that the impact would not matter is contrary to principles of good research and entirely untenable.

102.4. Finally, Dr Soderlund defended his regression analysis against claims of poor fit, poor data, and bias by stating that while his model may have some errors inherent from the approach and data and that his regression results may fail a standard for reasonable doubt (from criminal conviction), yet that they would pass a different standard “…the standard approach of science (including medicine and economics) to make ‘best informed’ decisions in complex, multi-factorial systems.”

103. While we agree that the regression model does not pass the reasonable doubt standard, neither does it pass even the standard that he proposes. The accepted standard includes that the model must accurately capture reality; that where needed it can distinguish causation from association; that its estimates are unbiased; that the regression specification and model are not subject to simultaneity, autocorrelation, omitted variables or other issues that impose bias or inaccuracy; and that its results are robust to small, but reasonable changes in specification. Dr Soderlund’s regression and analyses fail these tests and standards in multiple ways. They are not based on sound econometric principles and consequently do not provide a reliable basis from which any inferences can be made with regard to so-called Supply Induced Demand.

104. Dr Soderlund’s regression model and analyses fail these basic tests and standards in multiple ways. They do not provide a reliable basis from which any inferences can be made with regard to Supply Induced Demand and are not based on sound econometric

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A leading treatise on econometric evidence by Dr Daniel Rubinfeld notes: “Failure to develop the proper theory, failure to choose the appropriate variables, or failure to choose the correct form of the model can substantially bias the statistical results—that is, create a systematic tendency for an estimate of a model parameter to be too high or too low.” In addition: “The issue of robustness—whether regression results are sensitive to slight modifications in assumptions (e.g., that the data are measured accurately)—is of vital importance. If the assumptions of the regression model are valid, standard statistical tests can be applied. However, when the assumptions of the model are violated, standard tests can overstate or understate the significance of the results.” Daniel Rubinfeld, “Reference Guide on Multiple Regression” in Reference Manual on Scientific Evidence, Third Edition, by The National Academies Press (2011). Washington, DC: https://doi.org/10.17226/13163.
In summary, the regression analysis performed by Dr Soderlund has a number of substantial shortcomings that invalidate the conclusions reached by Dr Soderlund and the HMI including, but not limited to the following: 1) the regression analyses cannot prove that additional new hospital beds are causing admissions, 2) in any event, the relationship derived from the regression model is practically very small and so low so as not to be meaningful, and 3) even the small effect magnitudes disappear when a few necessary corrections are made to the methodology to address sources of bias.

The Competition Appeal Court in pronouncing on the role of, and approach to, economic experts in a competition law context has held as follows:

“[180] This concern about the impartiality of expertise and its implications for complex cases such as the present was captured by Lord Woolf in Interim Access to Justice Report (Interim Report to the Lord Chancellor on the Civil Justice System) in England and in Wales (1995). See ch 23 at para 5:

'Most of the problems with expert evidence arise because the expert is initially recruited as part of the team which investigates and advances a party's contentions and then has to change roles and seek to provide the independent expert evidence which the court is entitled to expect. As Lord Wilberforce in The Ikarian Reefer (1993) 2 Lloyds Reports 68 stated:

'It is necessary that expert evidence presented to the court should be and should be seen to be the independent product of the expert uninfluenced as to form or content by the exigencies of litigation.

'In many cases the expert, instead of playing the role identified by Lord Wilberforce, has become . . . a very effective weapon in the party's arsenal of tactics.'

[181] This approach finds support in the leading South African authority, Zeffertt & Paizes South African Law of Evidence 2nd ed, who at 330 cite favourably from The Ikarian Reefer, which judgment they consider reflects adequately the duties and responsibilities of expert witnesses:

‘1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation (Whitehouse v Jordan [1981] W.I.R. 246 at 256 per Lord Wilberforce).
2. An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within his expertise (see Polivitte Ltd v Commercial Union Assurance Co. Plc., [1987] Lloyd’s Rep. 379 at 386 per Mr Justice Garland and Re J [1990] FCR 193 per Mr Justice Cazalet). An expert witness in the High Court should never assume the role of an advocate.

3. An expert witness should state the facts or assumption upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion (Re J supra).

4. An expert witness should make it clear when a particular quotation or issue falls outside his expertise.

5. If an expert’s opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one (Re J sup.). In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report (Derby & Co. Ltd. and Others v Weldon and Others, The Times, Nov. 9, 1990 per Lord Justice Staughton)…”

[182] It is these guidelines which should be followed in future hearings before the Tribunal. Suffice to say that in this case, once the issue of feedstock costs had been resolved, the appellant placed before the Tribunal impressive and cogent evidence which, sadly, was not properly gainsaid by the Commission, to the extent that it would have been justified to conclude on the probabilities that the Commission’s case should have been upheld. To the contrary, figures cited without any clear and reasoned justification do not constitute expert evidence. Further, an expert in a defined area is not necessarily an expert in another defined area. The Tribunal must in future guard against expert overreaching.” ¹¹⁴ (Our emphasis)

107. These principles set out by the Competition Appeal Court are equally applicable to how the independent panel conducting a public competition market inquiry must approach

expert evidence that serves before it.

108. It is respectfully suggested that Dr Soderlund’s attempts to still seek to place reliance on his regression model for purposes of seeking to assert a theory of Supply Induced Demand, notwithstanding the various obvious flaws in the model and the data on which it relies, is an unfortunate example of expert overreaching, which should be discouraged.

109. In conclusion on the Supply Induced Demand theory advanced by the HMI, which is largely based on Dr Soderlund’s regression model, it is evident from various of the third party submissions in respect of the provisional report and from the submissions made at the seminar dealing with this topic, that no reliance can be placed on Dr Soderlund’s model for the purposes of supporting any recommendations or remedies proposed by the HMI. Dr Soderlund himself has acknowledged the material shortcomings of the model (incomplete data, inability to demonstrate causation, crucially the inability to demonstrate that any actions by hospitals induce demand). In the face of Dr Soderlund’s own concessions as to the defects in the regression model, allied with the third party critiques of the regression model, including bias and numerous methodological flaws, it is respectfully submitted that it would be irrational, unreasonable and procedurally unfair to place any reliance on Dr Soderlund’s regression model or his interpretation or views flowing from the model, for purposes of the HMI making any recommendations or devising any remedies related thereto.

110. While there is no evidence (independent of Dr Soderlund’s regression) supporting a physician-based Supplier Induced Demand theory which has been put forward by the HMI, in the event that the HMI were to have any residual concerns in this regard, it could consider and evaluate certain potential recommendations that could conceivably address possible incentives to over-service, which may potentially arise from physicians’ ownership interests in hospitals, or other forms of incentive arrangements.
F. EFFICIENCY CONSIDERATIONS

111. There still appears to be some suggestion during the seminars that certain of the larger facilities are not conducting their operations on an efficient basis or are opening facilities which are uneconomic or inefficient.

112. As previously pointed out, while the HMI seeks to rely on the NMG expenditure analysis as evidence that facilities are inefficient operators, it is important to note that this is not an analysis of efficiency. First, the dataset upon which the analysis in the HMI Facilities Report is based is incomplete and of poor quality. For example, it does not appear to contain data on the costs incurred by hospitals (which is essential to estimate cost efficiency); nor on key input prices or input levels (again, essential ingredients for estimating cost or technical efficiency using efficiency frontiers), nor certain variables which have been identified in the healthcare economics and efficiency analysis literature as being important (such as size, speciality, available technologies, or access to specialists).

113. Despite the HMI’s apparent reliance on the analysis in the Facilities Report to draw conclusions about the inefficiency of firms that operate private healthcare facilities in South Africa, it does not appear to consider in the Provisional Report or the Facilities Report the fundamental concepts that underlie efficiency analysis, or any of the well-established analytical approaches to estimating it. In particular, the HMI does not appear to:

113.1. explain what type of efficiency it is assessing, i.e. whether its assessment relates to technical efficiency, allocative efficiency, or overall cost efficiency. At times, the HMI uses the term “inefficiency” in relation to prices: “the persistent reliance on FFS [fee-for-service] tariffs and the lack of meaningful diversion towards ARMs [Alternative Reimbursement Models] also exposes the inefficiency inherent in the hospital tariffs”. Such comments reveal that the HMI does not consider the fundamental concepts that underlie an analysis of efficiency. As explained in Section 3 of Dr Meschi of FTI’s report, inefficiency has to do with a firm’s costs, not its prices. If costs are found to be inefficient and if prices are based on a mark-up over those inefficient costs, then one might infer that those prices are ‘excessive’ or ‘anticompetitive’. However, the HMI has not performed an analysis of cost efficiency,
and the HMI considers that “the levels of profits are not in themselves a concern”;

113.2. present any estimate of the level of efficiency, such as in the form of a relative efficiency score;

113.3. explain how any efficiency assessment deriving from the HMI’s analysis can provide an overall assessment of the efficiency of private healthcare facilities in South Africa when the underlying dataset does not contain any data against which to benchmark these facilities (since the dataset does not contain, for example, data relating to facilities outside of South Africa); and

113.4. make any reference to bottom up efficiency assessment, or efficiency benchmarking / frontier-based approaches.

114. Given this, it is not clear how the expenditure analysis can be said to have “revealed levels of inefficiency”.

115. There are several standard approaches to assessing cost efficiency in regulatory and competition contexts. None of these approaches have been used by the HMI to determine the efficiency of the facilities. In violation of its own guiding principles, the HMI has not adopted a best practice approach, nor used a methodology that supports rigorous analysis. The HMI presents no evidence on the cost efficiency of facilities, its assertions on inefficiency are entirely unsupported, and therefore cannot be used as a permissible basis for its further findings and recommendations.

116. In conclusion, as is made clear in Dr Meschi’s (FTI) expert report, the HMI’s analysis cannot have been designed to assess efficiency and the HMI’s statements in regard to the alleged “inefficiency” of the three large hospital groups is entirely devoid of any factual basis and is completely at odds with accepted economic practice in testing efficiency.
G. CONSTITUTIONAL CONSIDERATIONS IN THE CONTEXT OF THE HMI’S MARKET INQUIRY

Introduction

117. An issue which has frequently arisen during the previous hearings and recent seminars convened by the HMI, is the extent to which the HMI can place reliance on the constitutional right of access to healthcare contained in section 27 of the Constitution in motivating for and underpinning various of the recommendations and findings contained in its final report.

The statutory context and scope of the HMI

118. The HMI was initiated by the Competition Commission (the “Commission”) in terms of its powers under sections 43A to C of the Competition Act.

119. Section 43A provides that the Commission may institute a formal market inquiry “in respect of the general state of competition in a market for particular goods or services.”

120. Section 43B(1) provides that:

“(1) The Competition Commission, acting within its functions set out in section 21(1), and on its own initiative, or in a response to a request from the Minister [not the Minister of Health, but the Minister of Economic Development], may conduct a market inquiry at any time ... (i) if it has reason to believe that any feature or combination of features of a market for any goods or services prevents, distorts or restricts competition within that market or (ii) to achieve the purposes of the Act.” (Our emphasis)

121. Section 2 provides that the overarching purpose of the Competition Act is to “promote and maintain competition in the Republic” in order to achieve certain outcomes including “to promote the efficiency, adaptability and development of the economy,” “to provide consumers with competitive prices and product choices,” and “to promote employment and advance the social and economic welfare of South Africans.”115 In other words, the purpose of the Competition Act is the promotion and maintenance of competition – this

115 Emphasis added.
purpose is envisaged to have beneficial consequences for society, but the Competition Authorities cannot seek to achieve these consequences outside of the scope of maintaining and promoting competition. That this is the case is underscored by the Preamble to the Competition Act, which refers to a “competitive economy,” “economic competition,” “competing,” “competitive economic environment” and an “efficiently functioning economy.”

122. Thus, while the purpose of promoting and maintaining competition is to achieve certain objectives, which can be achieved through a competitive economy (or market), the ambit of the Competition Act is limited to the promotion of competition (or efficient market-based outcomes). The Competition Act does not allow, or contemplate, attempts to achieve these subsidiary objectives other than by promoting and maintaining competition.

123. In terms of section 43A, read with section 43B, and the Competition Act as a whole, a market inquiry’s primary focus, one which the Panel is statutorily enjoined to undertake, is an investigation into competition issues said to arise in a specified market (including regulatory features of the markets in question which may hinder effective competition).

124. The Terms of Reference of the HMI make it clear that the purpose of the HMI is in line with this statutory scheme:

“A market inquiry is thus a general investigation into the state, nature and form of competition in a market, rather than a narrow investigation of specific conduct by any particular firm.

The Commission is initiating an inquiry into the private healthcare sector because it has reason to believe that there are features of the sector that prevent, distort or restrict competition. The Commission further believes that conducting this inquiry will assist in understanding how it may promote competition in the healthcare sector, in furtherance of the purpose of the Act.”

125. The Terms of Reference do note that one of the main objectives of the HMI is, inter alia, to “[m]ake recommendations on appropriate policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality

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116 Terms of Reference, para 1, GG pg 75, emphasis added.
private healthcare”.\textsuperscript{117}

126. Of course, this objective must be understood within the context of the Terms of Reference, and \textit{intra vire}s the Competition Act, to mean that the HMI can make recommendations on appropriate policy and regulatory mechanisms to promote or maintain competition in the private health care market, which would then support “the goal of achieving accessible, affordable, innovative and quality private healthcare”, by way of more efficiently operating markets.

127. As the Chairperson of the HMI made clear at the start of the HMI, “[m]arket inquiries are essentially ‘research projects conducted to gain in-depth understanding of how sectors, markets, or market practices are working.’\textsuperscript{118} The purpose of the exercise is to determine whether the process of competition is working well or can be improved effectively in a market as a whole. Market inquiries provide a framework for identifying, analysing and, where appropriate, remedying sector-wide or market-wide competition problems.”\textsuperscript{119}

128. As the Chairperson emphasised, that although “[t]he remit of the panel derives from the terms of reference… [t]he Panel’s approach to the inquiry is to proceed wholly independently of what may have prompted the Competition Commission to initiate the inquiry and to cast a fresh pair of eyes on the issues raised in the terms of reference. It is therefore possible that after considering all the evidence the Panel may conclude that there are no features that prevent, distort or restrict competition in the private healthcare markets. This is the approach that is followed in other jurisdictions, in particular, in the UK, and we think this is a sound approach to follow.”\textsuperscript{120}

129. In a speech to stakeholders in February 2016, the Chairperson also (with respect) correctly stated that “[i]t is important to emphasise that the scope of our inquiry is limited by the Competition Act as well as the Terms of Reference, which sets out our core

\textsuperscript{117} Emphasis added.
\textsuperscript{118} Market Studies Good Practice Handbook, International Competition Network (ICN Handbook) at pg 6. (internal original footnote retained).
\textsuperscript{119} Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014, pg 5-6, emphasis added.
\textsuperscript{120} Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014, pgs 9-10, referring to UK Competition Commission Guidelines for Market Investigations: Their Role, Procedures, Assessment and Remedies, April 2013. (CC 3 Revised) at paragraph 22. Emphasis added.
mandate.”\textsuperscript{121} (Our emphasis)

Accordingly, the remit of the inquiry in terms of the Competition Act and the Terms of Reference, is an investigation into whether there are features of the market which prevent, restrict or distort competition (what we refer to as “competition harms”) and, if so, how this can be remedied. An investigation into the reasons for any deficiencies or issues that are not competition harms (what we refer to as “non-market deficiencies”) and potential remedies for such non-market deficiencies are outside the scope of the Competition Act.

Moreover, in addition to the scope of the inquiry, the key consideration is that the findings of the inquiry must be located within a competition law framework. That means the findings must be focused on issues relating to competition law (i.e. features of the market that cause competition harms (that is, prevent, distort or restrict competition)). Importantly, in section 43C(1)(b), the Competition Act indicates that the recommendations that may be made to other regulatory authorities (and not the Minister of Economic Development) must relate to “competition matters.” This makes it clear that the Panel’s findings are limited to dealing with competition matters, in order to remedy market failure.

This has been confirmed by the Chairperson, who affirmed that “[a]t the conclusion of the inquiry, we are required to answer the question whether there are features that prevent, distort or restrict competition in the private healthcare markets. There is a whole range of outcomes that the panel may reach including a finding that the market is functioning well or that it is not functioning well.”\textsuperscript{122}

Thus, while the right of access to healthcare may provide context, it does not alter the nature or purpose of the inquiry, which is a competition investigation into a particular market.

While a proper understanding of relevant constitutional rights, particularly the right contained in section 27 of the Constitution may provide relevant context to the Panel’s competition law inquiry under the Competition Act, since the Competition Act correctly

\textsuperscript{121} Chairperson’s Remarks at the Information Session on Status of the Health Market Inquiry, February 2016, para 14 (available at \url{http://www.compcom.co.za/speeches/}), emphasis added.

\textsuperscript{122} Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014 pg 7, emphasis added.
accepts that competitive markets may ensure better realisation of a number of social goods, the purpose of the investigation is not an general inquiry into how constitutional rights or other public goods may be secured outside an efficiently operating market.

135. In this regard, submissions from certain stakeholders have used the phrase “market failure” as a basis for suggesting that intervention is required in relation to the private healthcare sector. However, their use of the phrase “market failure” appears to encompass a variety of concerns, which are not necessarily linked to specific competition considerations. In particular, they have used the term “market failure” to refer to scenarios, where even the most efficient and competitive markets could not deliver the desired outcomes. In other words, given levels of unemployment and income in South Africa, the private healthcare sector is not in a position to deliver quality healthcare to the majority of South Africans. This is not a consequence of “market failure” properly so-called (or what we refer to as a harm to competition). Rather, this is in fact a “non-market deficiency” (that is a deficiency, as explained above, that is not caused by any prevention, distortion or restriction of competition). As pointed out above, the inquiry is not about seeking to identify and redress non-market deficiencies, which are outside the scope of the Competition Act. That is for the simple reason that the Competition Act – and any market inquiry established thereunder – has a singular focus: of maintaining properly functioning competitive markets, by identifying and addressing competition harms.

136. The courts’ interpretation of the scope of the constitutional right of access to healthcare services may guide the Panel in contextualising its investigation into the state, nature and form of competition in the private healthcare market.

137. However, the scope and nature of the constitutional right of access to healthcare, serves only as a background to the HMI’s statutorily mandated scope of investigation. The HMI and the nature of any recommendations that may be made at the conclusion of the inquiry occurs under the clear discipline and constraints of its specific statutory regime (the Competition Act), and thus the HMI recommendations must be aimed, to the extent necessary, at remedying market failure (harm to competition) arising from specific competition law theories of harm (i.e. excessive pricing, refusals to deal, cartel conduct, exclusionary abuses of dominance), and not non-market deficiencies.
138. In relation to the scope and nature of the right of access to healthcare, it is also important to note that:

138.1. While private parties may, in certain limited circumstances, have a negative obligation to have due regard to whether their actions may impinge the right of access to healthcare services provided by the State, this is in contrast to – and no substitute for – the overarching and ongoing positive obligation that the State bears to ensure the right of access to healthcare services is progressively realised within the State’s available resources.

138.2. Efficient and competitive private health care can beneficially operate alongside public health and thus ensure enhanced access to health care services.

138.3. The State also has an obligation not to detrimentally affect access to private healthcare. Thus, while the State may take steps to regulate the private healthcare sector, as it has already done, its legislation and regulations must be reasonable and must be carefully tailored to progressively realise the right of access to healthcare services. Further, the State may not impede that right by, for instance, unreasonably limiting access to private healthcare services for those willing and able to pay for such services.

138.4. Any regulation of the private healthcare sector that fails the test of legality, that does not comply with the requirement of lawful, reasonable and procedurally fair administrative action, and/or that impermissibly impinges on the right to choose and practise one’s occupation, will be found to be unconstitutional and invalid.

139. In conclusion, while the right of access to healthcare as set out in section 27 of the Constitution, as interpreted by the courts, may provide a basis for how certain provisions of the Competition Act should be interpreted in the context of a market inquiry conducted in terms of the Act, it is not a self-standing basis for making recommendations or findings pursuant to any market inquiry under the Competition Act. In other words, absent identified evidence of specific competition harms which need to be remedied, it would not be competent to propose remedial measures in the context of a competition law inquiry, because the inquiry panel felt that the constitutional right of access to healthcare was not being given proper effect to due to non-market deficiencies. Such an approach, which is, with respect, precluded by the Competition Act, must be contrasted with a
markedly different, but permissible approach. If in the course of the inquiry specific competition harms are evidenced and identified, then in fashioning any remedies to specifically address those competition harms, the inquiry panel may have due regard to the constitutional right of access to healthcare when fashioning its competition remedies to address the identified theory of harm to competition.

H. APPROPRIATE REMEDIES: HARM TO COMPETITION A PREREQUISITE

a) The appropriate approach to making recommendations

140. The HMI indicates in the introduction to Chapter 10 of the Provisional Report, that its recommendations should be assessed against three specific requirements:

140.1. Any recommendations should be “appropriate” in the sense that the remedy must be measured against the harm it wishes to address, the effect on the stakeholders involved and the purpose it wishes to achieve;\textsuperscript{123}

140.2. The remedy must be \textit{practical} to implement;\textsuperscript{124} and

140.3. Any recommendations should also be considered against the \textbf{criteria used by the UK Competition and Markets Authority (“CMA”)} when considering its remedial action.\textsuperscript{125}

141. The HMI correctly points out that these principles are important because its recommendations, "\textit{may have notable effects on the rights and duties of affected parties.}"\textsuperscript{126}

142. In order to determine what would constitute appropriate recommendations, the principles that should properly guide the design of any recommendations are those embodied in the definition of proportionality, as clearly set out by the UK CMA’s Guidelines for market investigations. The HMI itself indicates in the Provisional Report that it drew on the CMA’s approach in designing its remedial recommendations. In particular, the CMA (in

\textsuperscript{123} See the Provisional Report, paragraph 9-10, p 455.
\textsuperscript{124} See the Provisional Report, paragraph 12, p 455.
\textsuperscript{125} See the Provisional Report, paragraph 13, p 455.
\textsuperscript{126} See the Provisional Report paragraph 8, page 454. Emphasis added.
line with established European Case law) designs remedies by considering whether remedies are likely to be proportionate, where a proportionate remedy is one that:

142.1. is effective in achieving its legitimate aim;
142.2. is no more onerous than needed to achieve its aim;
142.3. is the least onerous if there is a choice between several effective measures; and
142.4. does not produce disadvantages which are disproportionate to the aim.

143. The HMI rightly accepts that remedies must be proportionate (tested against the above criteria) since it notes that when assessing “appropriate”, this principle “suggests that the remedy must be measured against the harm it wishes to address, the effect on the stakeholders involved, and the purpose it wishes to achieve. Simply put, there must be a fit between the recommendations made and the harm they wish to address.”

144. Ultimately, the Inquiry in general and the HMI’s recommendations in particular, have to be tested against the standards of lawfulness, rationality, reasonableness, and procedural fairness. As was pointed out during the recent seminars, if the HMI’s recommendations fail to meet the criteria it has set for its own recommendations (for instance appropriateness and practicability), then clearly those remedies would be irrational and unreasonable. We discuss these issues in more detail below.

145. As will be demonstrated in more detail below, certain of the HMI’s potential recommendations are not warranted for, among others, the following reasons. By way of overview:

145.1. Some of the recommendations such as potential divestiture, are often couched in such vague and uncertain terms that it is impossible for stakeholders to make meaningful comments on them, even at this very advanced stage of the proceedings. This alone renders the process procedurally unfair and unlawful.

145.2. Certain of the recommendations such as potential divestiture, price regulation, caps or moratoria on licences etc. are not supported in any respect by the available evidence.

127 See the Provisional Report, paragraph 11, p 455.
146. Furthermore, a number of the proposed recommendations such as multi tariff setting through the auspices of a Supply Side Regulator, cannot be lawfully implemented within the current legislative framework, absent legislative amendment or new legislation being enacted.

Facilities recommendations

147. In relation to potential remedies to address the HMI’s provisional finding of “highly concentrated” national markets, the HMI proposed a number of potential remedies at paragraph 49 of its note on facility concentration of 2 April 2019, which included inter alia the following:

“49.1 The formulation of a national licensing policy framework with standardised criteria across all regions in SA, however retaining the role of implementation of the issuing of licences at the Provincial level;

49.2 licences be issued to facilities certified by the Office of Health Standards Compliance (OHSC) in collaboration with the proposed Supply Side Regulator for Health (SSRH);

49.3 licensing to take into account capacity and capacity needs (number of beds per risk adjusted capita) in both the private and the public sectors hence the need to apply the appropriate regulations for the granting of the certificate of need (CON) in line with a centralised national licensing framework for all health establishments;

49.4 to adopt strict reporting requirements for licence renewals, penalties for non-compliance and regular monitoring, inspection and reporting;

49.5 to notify the sale of licences to the Competition Commission, SSRH and the provincial departments of health (PDoH);

49.6 competition authorities to take measures to prohibit creeping mergers in the facilities market; and

49.7 discuss the appropriateness, proportionality and effectiveness of possible divestiture and moratorium measures on issuing licences to the three large
hospital groups (Netcare, Life and MediClinic) until such time as the national market share of each of the big three hospital groups, by number of beds, is no more than 20%. ”128 (Our emphasis)

148. These recommendations were similar in substance and in form to the recommendations which had been proposed by the HMI in the Provisional Report in Chapter 10.

Concentration on its own does not imply harm to competition

149. Submissions from a number of stakeholders during the seminar on facility concentration confirmed the position that findings of certain levels of concentration are not in and of itself sufficient for purposes of arriving at a view that there is a competition harm, which needs to be addressed.

150. Various stakeholders have underlined the principle that even if there were potentially to be a finding that certain of the markets are concentrated markets, such a finding cannot without more provide the basis for a proposed intervention, particularly where no cogent theory of competition harm has been shown to exist. The Seminar Note on Facilities itself states that129:

“The HMI also acknowledges that the existence of high concentration in the facilities market may not necessarily lead to the existence of market power or to perverse outcomes

- And that “there may be valid reasons for high concentration””

151. As one stakeholder pointed out that “[t]here is no sound economic basis to link or HHI level with the ability to exercise market power” and that such an analysis would require “examining the linkage between concentration and market power using industry-specific data”.130

128 Seminar Note: Overview of HMI Funders’ market concentration and remedies. Published on 2nd April 2019, pages 19 and 20.
152. When considering the analysis of “industry-specific data”\(^{131}\) which had been conducted by the HMI, several stakeholders pointed to the fact that there have been no findings by the HMI to the effect that any of the facilities were charging excessive prices, making excessive profits, engaging in abuses of dominance such as refusals to deal and/or had engaged in cartel conduct. This is borne out by several statements by the HMI:

“The Inquiry’s view is that beyond what can be explained by the demographic and clinical factors, increasing utilisation over time explains the bulk of the increase in hospital expenditure as seen in the increase in admissions, average length of hospital stay (LoS) and level of care (LoC).”\(^{132}\)

“When assessing the tariff increases, these appear to be marginally within the CPI increases…”\(^{133}\)

and

“The ROCE therefore presents a more representative indication of the profitability of the relevant firms and their development over time during the relevant period. The profitability analyses suggest that the relevant firms show consistently profitable margins over and above the long-term cost of capital. However, the margins do not appear to be excessive when compared to the WACC. The average results of the profitability analyses indicate however that the relevant firms are consistently making fairly stable economic profits and that these profits are not decreasing over time as a result of competitive forces.”\(^{134}\) (emphasis added).

153. During the course of the seminars the Chairperson of the HMI confirmed that, “you are absolutely right, we haven’t found hard evidence in the pricing the way that the enquiry did at prices in the way they did because we were not convinced it would have been helpful. You know for us we have looked at profits of course and we found fairly consistent handsome profits of the hospital groups, some rising, some decreasing of it but handsome but not pointing to the use of market power. We have been clear on that


\(^{132}\) See the Provisional Report on page 227 at paragraph 322

\(^{133}\) See the Provisional Report on page 235 at paragraph 364

\(^{134}\) See the Provisional Report on page 251 at paragraph 457
I think” (Our emphasis)

154. In contrast, when considering the findings on the profitability of funders, the HMI found that “Medical scheme administrators with a substantial market share that persistently earn excess economic profits over a prolonged period of time, without the realistic threat of competitive entry, may have a degree of market power and be able to charge prices above the competitive level”136. In particular, the Provisional Report noted in respect of Discovery Health that “Over time, there has been a clear upward trend in Discovery Health’s [return on sales]” and “the observed level of profits for Discovery Health point to a degree of market power on the downstream market”.137

155. These findings are consistent with the views submitted by a number of stakeholders that (i) the funder market has become more concentrated over time while the facilities market has become less concentrated and (ii) that the funders enjoy significant countervailing power vis-à-vis the hospital groups and potentially there is need for enhanced competition among funders in the downstream market for beneficiaries.

Appropriateness and proportionality of HMI facilities’ recommendations

156. Insofar as the proposed recommendations to address competition and concentration concerns at a facility level are concerned, it would appear that there is a large degree of consensus that the facilities sector is not in fact “highly concentrated”. Furthermore, there is no evidence to suggest that facility prices are excessive or that there has been any other form of abuse of market power. In other words, there is no competition theory of harm which has been demonstrated which would require the imposition of any recommended remedy.

157. Against this backdrop, we will now turn to the two principal recommended remedies proposed in this regard.

The proposed remedy which would involve a form of pricing regulation (including the proposed bargaining through the auspices of the Supply Side Regulator) is neither appropriate nor proportional, nor is there a competition theory of harm which would

136 See the Provisional Report on page 246 at paragraph 431. Emphasis added.
137 See the Provisional Report on page 146 at paragraph 401.
support its implementation

158. There is no evidentiary basis to suggest that some form of price regulation, whether through a Supply Side Regulator or any other regulator, is warranted or required. Furthermore, there are a number of reasons why price regulation should not be considered as an appropriate, practical or proportional remedy in the circumstances. Price regulation is not proportionate or easy to implement. Setting prices is a complex and time-consuming process, even when there are few tariffs or reference prices for specific services. Reference pricing requires establishing a specific price for each service for all hospitals that can change as market conditions change and that provide sufficient returns. Government regulation of healthcare prices is fraught with complexities that make it unlikely that the results of such a regulatory price setting process would approximate equilibrium prices that would be established in a competitive market. The market, as in the case of the development of networks, is likely to achieve greater efficiency without government price intervention.

159. International agencies, such as the CMA and the US Federal Trade Commission and Department of Justice, after similar inquiries have chosen to rely on competition rather than extensive new pricing regulation. The CMA rejected price regulation in favour of bi-lateral negotiations noting that “... a price control regime would be very difficult and costly to set up ...and to update, to take account of both the introduction of new treatments and procedures, and movements in costs over time. We therefore decided that a price capping regime would not be effective in the long term, and would not be proportionate.”

160. There appeared to be some degree of consensus from both facilities and funders that bilateral negotiations between funders and facilities should continue and while some funders seemed to also be comfortable with some form of multilateral tariff setting arrangement under the auspices of a Supply Side Regulator, there was no compelling evidence put forward to support this proposal either from a competition law or a regulatory perspective. In other words, even those stakeholders which did not raise concerns relating to this proposal, did not point to any competition theory of harm to

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support this proposal nor did they indicate how it could be lawfully achieved within the framework of the existing legislation. As pointed out during the seminars and in response to the provisional report, it would not be possible to create the proposed Supply Side Regulator in terms of the current provisions of the National Health Act and the establishment of such a regulator would require legislative amendment.

161. During the course of the seminar, concerns were raised by members of the Panel that small independent players in the facilities market were not able to effectively negotiate with large funders and that this may be the motivation for the imposition of a multi-lateral bargaining process under the auspices of the Supply Side Regulator to ensure that the interests of these small players were protected.

“But, there is also a risk that some of the smaller schemes will not necessarily be deemed important enough by large hospital groups. And the reverse is also true. Where some of the larger funders might not deem it important to negotiate with small hospital groups.

Now, if that happens, we will still have gaps, potentially. So, the point is really that we are asking for comment with the understanding that the thinking is that all parties should still be part of the multi-lateral negotiation forum, for the simple reason that there has to be a tariff for every possible service that can be rendered out there in the industry”139 (Our emphasis)

162. In response, stakeholders noted that collective negotiations of this nature may have unintended consequences.

“So, if I understand your theory correctly, we’ve read in the provisional report about the tariff vacuum. I think there has been uncertainty around that. And I have heard you saying today that the idea of compulsory multi-lateral negotiations is A; to counter for the small hospitals, and B; to counter for the small schemes.

Now the question from an economic perspective is if you allow the small hospitals, we give them the opportunity to engage in this multi-lateral negotiation forum. In fact, what you are giving them is collective seller

139 Competition Commission Health Market Inquiry Seminar: Session 3, 10 April 2019 on page 3.
power. So, you are increasing their power through collective bargaining, which will end up in a higher price for those small hospitals.

The issue is that the market can solve this. There is an exemption currently by the NHN. So, I struggle to see what the pro-competitive outcome is of a system that will necessarily increase price, for those hospitals that can't compete.” 140

163. The concern that there may potentially be an inability on the part of a small number of small hospitals to negotiate effectively, would not warrant the establishment of a Supply Side Regulator, particularly when there are existing market mechanisms which such entities could deploy to address such concerns. For example, there is nothing which precludes small hospital groups from joining the NHN which has an exemption to negotiate jointly on behalf of several facility groups in South Africa.

164. NHN currently has an exemption to negotiate collectively until 2023. The Commission first granted the NHN an exemption on 15 June 2006, followed by another exemption on 21 May 2010 and then on 31 January 2014. These exemptions have allowed NHN to grow significantly over the years.

165. In its December 2018 newsletter, the NHN notes that “We have also recently been granted exemption by the Competition Commission for another five years. Our exemption gives us the freedom to collectively conclude tariff negotiations, conduct central procurement, and negotiate global fee agreements on behalf of NHN members. This exemption underscores the influence of the NHN as a collective.” 141

166. The overall total number of NHN hospitals has increased significantly between 2010 and 2018. In addition, the Medscheme submission to the HMI showed that NHN had a dominant position in day clinics (76%), in Sub-acute facilities (66%), mental health (80%) and cataracts (41%).

167. In addition, to the extent that a group of independent facilities wishes to negotiate collectively outside of the NHN, then they also have the option of applying to the Competition Commission in terms of Section 10 of the Act for a separate exemption

140 Competition Commission Health Market Inquiry Seminar: Session 3, 10 April 2019 on page 58.
141 National Hospital Network Newsletter, Issue 2, November 2018.
allowing them to negotiate collectively.

168. In addition, stakeholders also pointed to the Competition Amendment Act which, once implemented, would afford substantial protections to small and independent hospital groups when negotiating with large funders.

“Chief Justice, sorry, just one small comment from my side. I’ve heard the comments and concerns articulated by Dr Bhengu. But I would also suggest that before the HMI comes to any definitive conclusions on this issue, that perhaps you also want to look at the amendments to the Competition Act which have been published, and particularly the provisions dealing with price discrimination, and exclusionary conduct, which apply particularly to small and medium-sized enterprises and previously disadvantaged firms.

And the provisions in the Act may well address the concerns that Dr Bhengu has raised, rather than having to go through the rigmarole of setting up a massive infrastructure at significant cost.”

169. The new provisions in the Competition Amendment Act (reflected below) already address concerns around how large firms deal with SMMEs and businesses owned by historically disadvantaged individuals without the need for the establishment of a Supply Side Regulator.

“(8)(4)(a) It is prohibited for a dominant firm in a sector designated by the Minister in terms of paragraph (d) to directly or indirectly, require from or impose on a supplier that is a small and medium business or a firm controlled or owned by historically disadvantaged persons, unfair – (i) prices; or (ii) other trading conditions.

(b) It is prohibited for a dominant firm in a sector designated by the Minister in terms of paragraph (d) to avoid purchasing, or refuse to purchase, goods or services from a supplier that is a small and medium business or a firm controlled or owned by historically disadvantaged persons in order to circumvent the operation of paragraph (a).” (our emphasis)

142 Competition Commission Health Market Inquiry Seminar: Session 3, 10 April 2019 on page 71.
And

“(9)(1A) It is prohibited for a dominant firm to avoid selling, or refuse to sell, goods or services to a purchaser that is a small and medium business or a firm controlled or owned by historically disadvantaged persons in order to circumvent the operation of subsection (1) (a) (ii).”

170. As such, concerns relating to the alleged difficulties faced by small independent hospitals in the ordinary bi-lateral negotiation process, for the reasons set out above does not provide any basis for the introduction of a wide-ranging and fraught multi-lateral pricing process under the auspices of the proposed Supply Side Regulator. Simply put, there is no competition law theory of harm which has been identified and which needs to be addressed and the recommendation of a form of price regulation which has been rejected by comparable competition authorities for good reason would not be either appropriate or proportionate in the circumstances.

*The proposed remedy involving divestiture or a moratorium on the issuing of new hospital licences to Netcare, Mediclinic and Life is neither appropriate nor proportional, nor is there a competition theory of harm which would support its implementation*

171. Similarly, there is no basis on any of the existing evidence dealing with concentration or any of the other theories of harm, for making recommendations relating to potential divestiture, or moratoriums on new licenses being awarded to the three large hospital groups. These types of remedies are far reaching and highly invasive remedies and clear-cut and definitive evidence would be required, before a rational or reasonable recommendation in this regard could be made. As previously pointed out, the evidence in regard to the facilities sector is consistent with large scale new entry by independents and the NHN, relatively low barriers to entry and a moderately concentrated national market. For example, Medscheme noted that the HMI needs “to consider the current market dynamics, things have changed significantly in the last few years”\(^\text{143}\) and that the HMI would need to review not only the concentration analysis but also the “recommendations based on expansions, the specialities, growths, mergers, acquisitions and as well as the changes in terms of networks”\(^\text{144}\).


172. The analysis of various local markets conducted by the HMI is fatally flawed, contradictory and relies on a controversial and flawed methodology from a competition law perspective. In summary, there is no legal or economic basis for making recommendations relating to divestiture, market caps or moratoria or certificates of need in the context of the HMI’s findings on concentration levels in the facilities’ sector, or as a result of any of the other analyses performed by the HMI.

173. Notwithstanding the absence of any evidence to show that there are any competition law theories of harm applicable to facilities, there is also strong consensus on certain recommendations which are seen as being able to improve market outcomes for the overall benefit of consumers.

174. Netcare supports the principle that validated and relevant information on healthcare outcomes can support continuous improvement within the healthcare system, as well as conceivably provide patients and funders with information to make informed value-based choices. Netcare also endorses the need to reduce information asymmetry in order to enable relevant stakeholders, such as schemes and patients, to make informed decisions about the optimal treatment regime for their particular conditions, both in relation to hospitals and treating physicians.

175. Netcare would suggest that the following factors need to be taken into consideration in developing a system to publish Hospital Quality data:

175.1. Any reporting system must include both the public and private sectors;

175.2. The type and level of data required to establish the relevant benchmarks requires national data, including public sector data. For example, information on maternal mortality data in SA that was submitted to the World Health Organisation in recent years was substantively impacted by the inclusion of private sector data. Differences in measures and definitions will impact monitoring of national health outcome goals.

175.3. Netcare recommends that the Lancet Commission on High Quality Health Systems (HQSS) work needs to be incorporated into this process.

175.4. Netcare would suggest that the HMI has regard to the paper published by Insight Actuaries & Consultants on Quality Measurement and Reporting in September 2017.
and, in particular, section 9.1:

“Various Patient Reported Outcome (PROM) measures are also becoming popular. Several were pioneered in the UK NHS65. For example, the Western Ontario and McMaster Universities Arthritis Index (WOMAC) is a set of short, standardized questionnaires for evaluating the condition of patients with osteoarthritis of the knee and hip, covering pain, stiffness, and physical functioning of the joints. The NHS has also used PROMs for varicose vein and inguinal hernia surgery. 2 There are few other examples of PROMs being published, however their use is predicted to expand with the availability of inexpensive electronic means of collection, and the standardisation of measurement tools for various populations, as seen in the PROMIS project. Experience with PROMs in South Africa is very limited. Anecdotally, there are providers using WOMAC and other survey instruments but there are no related publications.” (our emphasis)

175.5. Netcare fully supports the need for comprehensive, hospital quality data. It goes without saying that hospital quality data with the right variables and definitions is crucial for credibility of data. Netcare strongly believes that in order for any quality measurement and outcomes system to succeed, it is imperative that healthcare physicians and practitioners are actively required to participate in the process of developing quality measures. It should be recognised in this regard that healthcare practitioners have a very significant impact on health outcomes through their skill, choice of treatment and behaviour. It should also be borne in mind that hospitals do not have access to physicians and practitioners patient notes, etc. and that a quality measurement and reporting system would need to incorporate healthcare professionals, if it is to operate effectively.

176. Other potential proposals which appear to enjoy wide-spread support include:

176.1. centralised licensing as opposed to the introduction of a certificate of need (which as pointed out is not warranted on the evidence and is not legally competent in the current circumstances given the absence of regulations dealing with certificates of need);

176.2. the removal of unnecessary barriers and the provision of more information and
transparency for consumers;

176.3. continued bilateral negotiations for hospital groups and funders;

176.4. zero rating of health care for the purposes of VAT;

176.5. encouraging the use of ARMs;

176.6. allowing independent hospitals to create networks such as the NHN, which are permitted to negotiate collectively;

176.7. reviewing the HPCSA ethical rules, which preclude the corporate ownership of radiology and pathology practices to assist in the development of integrated care models; and

176.8. the industry-driven introduction of a national DRG.

177. There also appears to be a large degree of consensus amongst funders and facilities on a review of the HPCSA rules, to allow the employment of doctors and to address any unintended limitations on development of integrated care models. Put differently, the HPCSA rules impose restrictions which preclude the development of multi-disciplinary and multi-faceted offerings, which may have a significant impact on the cost and quality of care.

178. To the extent that the HMI may have any residual concerns regarding the potential risk of over-servicing by medical practitioners (for which there is no meaningful evidence), consideration could also be given to whether the imposition of restrictions on shareholdings of medical practitioners in facilities, may address any such conceivable concerns in relation to risk of unnecessary admissions.
Funder recommendations

179. In relation to remedies to address the HMI’s provisional findings in the funder market, the HMI proposed a number of remedies in its note on funder concentration and countervailing power of 2 April 2019 which included the following:\textsuperscript{145}:

\begin{quote}
“standardisation of benefits”;
\end{quote}

\begin{quote}
‘risk adjustment mechanism’;
\end{quote}

\begin{quote}
“outcome registration and reporting in order to facilitate contracting on value for money instead of FFS only’’;
\end{quote}

\begin{quote}
“measures to address transparency:

a. Administrators to report on the value and outcomes of all ARM\textsubscript{s}, PPN\textsubscript{s}, and DSP arrangements;

b. That administrators’ comparative performance on a number of metrics are publically reported and measured against a national average; and

c. That the CMS produce a biannual report which reports on the value of managed care services, the extent of risk transfer, and savings pass-through’’;
\end{quote}

\begin{quote}
“Measures to address scheme employee (e.g. principal officers and trustees) performance. Notably:

a. That remuneration packages be linked explicitly to the performance of schemes, measured by value delivered to members. This is closely linked to the implementation of the CMS remuneration framework, which the HMI supports; and

b. A set of core competencies for trustees also needs to be developed, taking into account the diversity of expertise required.”;
\end{quote}

\textsuperscript{145} Seminar Note: Overview of HMI Funders’ market concentration and remedies, published on 2nd April 2019.
“regional based schemes are allowed to enter the market”;

and

“provider networks which are contracted on a purely FFS basis should be open to any willing provider who is able to match the negotiated tariffs. Networks which are contracted on ARMs which include additional metrics such as value, volumes, quality, etc. require selective contracting in order to be effective and therefore are not required to be open to any willing provider.”

Netcare and other stakeholders’ views on funder recommendations

180. As was indicated during the seminars, Netcare broadly supports the inclusion of primary care in benefit packages, the establishment of a standard basic medical scheme benefit package, the introduction of a low-income medical scheme product, the introduction of a risk equalisation fund, and the introduction of a risk based solvency approach. In addition to these broad remedies, Netcare also supports the establishment of a mandatory membership regime, a remedy which had not been advanced by the HMI, but which appears to have broad support from a variety of other stakeholders.

181. While the HMI noted in its Provisional Report the potential significant benefits from mandatory membership in reducing anti-selection risks and in reducing costs (as well as general stakeholder consensus on these benefits), the HMI demurred from recommending mandatory membership based on findings of alleged Supply Induced Demand, high and increasing costs, and alleged contracting issues between funders and facilities:

“We note that stakeholders submitted that mandatory membership of all people earning above a defined income threshold would reduce anti-selection risk. This is true and though the inquiry supports the principle of mandatory membership, we do not believe that it should be implemented within the current flawed system. At this stage, mandatory membership would simply add more beneficiaries into a system with high and rising costs, significant SID, limited competition and no incentives to create value for members.”146

“[M]andatory membership does not change the current contracting with

146 See Provisional Report, page 461.
provision, providers or over utilisation of healthcare services in the system”¹⁴⁷

182. It is submitted that the HMI should reconsider its stance in this regard in light of the submissions from various stakeholders during the seminars. Moreover, Netcare’s experts pointed to the significant savings that would be achieved through mandatory membership, which could equate to approximately R12.4 billion in savings per annum, which would dwarf any cost benefits achieved through any of the other proposed recommendations:

“Netcare experts quantified significant potential benefits from mandatory membership: “Assuming a 10% saving for the market overall, in line with published SHI estimates and more recent work, mandatory membership would result in a saving per capita that would equate to a R12.4 bn saving per annum. This significantly outweighs other remedies put forward in the Provisional Report.” (Barry Childs, Insight Actuaries, p 5)”¹⁴⁸

“Enhancing incentives for new entry by making entry more attractive – e.g. growing the market by stabilising the risk pool (such as through the NHI or mandatory membership) and more generally encouraging public facilities to acquire excess capacity from private facilities”¹⁴⁹ (emphasis added)

“Mandatory membership is the best mechanism to enhance cross-subsidies”¹⁵⁰

“Regulatory reform aimed at ensuring the stability and viability of the medical scheme risk pool, including

1. A risk-equalisation mechanism

2. Introduction of a standard basic medical scheme benefit package

3. Mandatory participation of formally employed

¹⁴⁷ See Chapter 7 and 8 on Practitioners and Facilities as well as Chapter 9 on Supplier Induced Demand. Provisional Report, Annexure 5.1.
¹⁵⁰ Workshop 1: Facilities market concentration and remedies, 9th April 2019, at page 12.
4. The introduction of a risk based solvency approach for medical schemes”.  

Supply Induced Demand recommendations

183. In relation to potential remedies to address the HMI’s provisional findings in relation to so called excessive utilisation and Supply Induced Demand, the HMI proposed a number of remedies in its note of 4 April 2019 which included among others the following:

“The HMI wants to reiterate the interventions that it has proposed to assist in curbing SID:

a. The introduction of a single comparable base scheme option with a risk adjustment mechanism to drive competition between schemes so as to force more vigorous supply side negotiations

b. Measurement of and transparent reporting of health outcomes to allow for value purchasing and to improve scheme member ability to choose providers and interventions

c. A health technology assessment function to curb inappropriate purchase and utilisation of health care technology or prevent third party payment when non-recommended technology is used

d. Provision of guidance on best treatment options

e. Methods to control prices through a Supply Side Regulator

f. Changes in the HPCSA ethical rules to promote innovation in models of care to allow for group practices and alternative care models so that fee-for-service ceases to be the dominant payment mechanism

g. Changes to training curriculum for health practitioners”


^152 Seminar note: Excessive utilisation and Supplier Induced Demand, published on 4 April 2019, pages 12 and 13.
Netcare and other stakeholders’ views on Supply Induced Demand recommendations

184. The recommendations, *inter alia*, include sub paragraph (e) which proposes the establishment of a Supply Side Regulator to control prices and in the provisional report includes recommendations to enforce moratoria on licences and potential divestiture.

185. This recommendation has been addressed above in relation to the remedies which were proposed in relation to facilities, but for the sake of completeness, we have included a brief summary of Netcare’s view in this regard. In line with the views advanced by a number of other stakeholders, Netcare believes that the proposed remedies related to price regulation and/or moratoria on licences are not rationally or reasonably connected to theories of Supply Induced Demand (which have, in any event, not been proved by Dr Soderlund). It appears well accepted that theories of Supply Induced Demand are intrinsically linked to allegations of excessive utilisation or over-servicing, which are entirely unrelated to issues of pricing. Accordingly, it is unclear on this basis how price regulation would have any rational relationship to curbing alleged over-servicing or excess utilisation as a result of new hospital builds.

186. Similarly, moratoria on the issue of new licences to Netcare, Mediclinic and Life would appear to be unrelated to the evidence that most new hospitals which have been built, have been built by independents and members of the NHN. For example, Discovery noted during the course of its presentation on 9 April 2019 that it was, “*not in support of a blanket moratorium or capping of market shares for the simple reason that this might have unintended consequences which are yet untested in our market*, we don’t quite understand how that will play out and we are just worried about the impact of how it might play out from just a competitor point of view in the long run so while we agree that there has to be some kind of centralised focus and intervention from a licensing point of view this should be implemented in a certain way.”153 (Our emphasis)

187. In summary, there does not appear to be any reasonable or rational basis for concluding that remedies such as divestiture, price regulation or moratoria on licenses would appropriately and proportionately address the so-called theory of Supply Induced Demand.

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188. In any event, there is no sound factual or empirical evidence to support hospital-based theories of Supply Induced Demand or unnecessary utilisation – and hence no need for far-reaching and invasive interventions such as divestiture or moratoria etc. In this regard, Dr Soderlund’s regression model has been unequivocally shown to be fatally flawed from every possible conceivable angle and, accordingly, no reliance can be placed on it.

189. It has also been acknowledged by various stakeholders that funders already have tools to manage unnecessary utilisation, including: case management, threats of network exclusion, pre-authorisation, paying patients directly, doctor de-listings, coding audits and so forth. At the recent seminar on Supply Induced Demand, Discovery, *inter alia*, indicated in respect of Supply Induced Demand that:

> “Similarly, on managing the utilisation of hospitals, GEMS have mentioned it – we certainly are reducing, and have seen the quote from my colleague Dr Noach, we think we are currently cutting down around, unnecessary medical, non-urgent, non-emergent hospital admissions. We are probably cutting out roughly twenty to thirty percent of those”.

190. The quote from Ryan Noach noted that, “[o]ut of this preauthorization process, we’re (declining) 20 percent of admissions” and “We’re seeing a 31 percent decline by the onsite case manager of the admission rate.”

191. Netcare is of the view that there is utility in considering solutions to address potential avenues which could conceivably result in over-servicing related to physicians. In its submission to the HMI at the most recent seminar on Supply Induced Demand, Netcare identified some potential recommendations, which are likely to be less invasive and more likely to directly address any potential concerns of over-servicing or inappropriate treatment. These include:

191.1. anti-fraud enforcement;

191.2. completely outlawing physician-hospital incentive arrangements to the extent that

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they exist;

191.3. Review physician-hospital equity arrangements in order to prevent any unintended consequences of doctor shareholdings in facilities;

191.4. Review HPCSA guidelines and compliance to remove barriers to developing integrated delivery care models and remove barriers to hospitals and others employing doctors, subject to appropriate safeguards; and

191.5. Remedies to address adverse risk (mandatory membership and a risk equalisation fund).
I. CONCLUSION

192. Netcare has filed a very detailed written response to the HMI's provisional report and this submission should be read in conjunction with the more detailed response to the provisional report.

193. As indicated in this document and in the response to the provisional report, Netcare is of the view that the HMI needs to reconsider and revisit key preliminary findings that it has made in the Provisional Report, particularly in regard to concentration and so called Supply Induced Demand. In addition, Netcare does not support proposed remedies relating to facility divestiture, moratoria on new licences in respect of the three large hospital groups, the imposition of a certificate of need and/or price regulation through the auspices of a newly established Supply Side Regulator or any other regulator for that matter.

194. In short, there is no detailed evidence whatsoever to sustain a theory of competition harm which could potentially require the imposition of any of these types of remedies, nor is there any rational or reasonable basis for recommending these remedies from a competition law perspective in the context of the theories of harm advanced by the HMI. It is also apparent that these types of proposed remedies are highly invasive and far-reaching in nature and would be entirely disproportionate to any of the issues identified by the HMI during the course of the enquiry. There also does not appear to be wide-ranging support by stakeholders for these types of remedies. Moreover, the majority of stakeholders who presented during the recent seminars did not appear to actively support the proposed recommendations, which would involve divestiture or the imposition of moratoria on the granting of hospital licences to Netcare, Mediclinic or Life or the capping of the market shares of Netcare, Mediclinic or Life.

195. Netcare does, however, support recommendations related to the following matters listed below, which it believes will enhance competition and improve patient care, as well as potentially significantly reduce costs of private healthcare:

195.1. Mandatory medical scheme membership for individuals earning above a certain income threshold;

195.2. The establishment of a risk equalisation fund;
195.3. Broad-based publication of hospital quality data and health outcomes related to treatment of patients in order to ensure greater transparency of treatment outcomes in the manner envisaged above;

195.4. centralised licensing as opposed to the introduction of a certificate of need (which as pointed out is not warranted on the evidence and is not legally competent in the current circumstances given the absence of regulations dealing with certificates of need);

195.5. the removal of unnecessary barriers and the provision of more information and transparency for consumers;

195.6. continued bilateral negotiations for hospital groups and funders;

195.7. zero rating of healthcare for the purposes of VAT;

195.8. encouraging the use of ARMs;

195.9. allowing independent hospitals to create networks such as the NHN, which are permitted to negotiate collectively;

195.10. reviewing HPCSA ethical rules which preclude the corporate ownership of radiology and pathology practices to assist in the development of integrated care models; and

195.11. the industry-driven introduction of a national DRG.

196. There also appears to be a large degree of consensus amongst funders and facilities on a review of the HPCSA rules, to allow the employment of doctors and to address any unintended limitations on development of integrated care models. Put differently, the HPCSA rules impose restrictions, which preclude the development of multi-disciplinary and multi-faceted offerings, which may have a significant impact on the cost and quality of care.

197. To the extent that the HMI may have any residual concerns regarding the potential risk of over-servicing by medical practitioners (for which there is no meaningful evidence), consideration could also be given to whether the imposition of restrictions on shareholding of medical practitioners in facilities may address any such conceivable concerns in relation to risk of unnecessary admissions.
198. Netcare believes that these recommendations enjoy widespread support from various stakeholders and should be implemented as swiftly as possible in the public interest.