Dear Mapato

APRIL 2019 SEMINARS: HMI REQUEST FOR SUBMISSIONS

1 Introduction

1.1 We refer to the Health Market Inquiry ("HMI") seminars held on 9, 10 and 12 April 2019, respectively concerned with (i) facilities market concentration, (ii) funders market concentration, and (iii) supplier induced demand ("SID") and overutilization.

1.2 On 15 April 2019 the HMI issued a Notice to Stakeholders requesting that stakeholders, with reference to the aforesaid seminar topics, make "succinct submissions based on the seminar engagements highlighting mainly the key issues of commonalities as well as where there were critical differences in relation to the HMI proposed findings and recommendations debated during the 3 days."

1.3 This letter must be read together with Mediclinic's previous submissions and its presentations as this submission aims to be succinct in line with the HMI's request and does not repeat detailed and relevant content already submitted to the HMI.

1.4 Given that it was not possible to fully ventilate all relevant aspects of the HMI's Provisional Findings and Recommendations Report¹ ("Provisional Report") in the 3 days in which the seminars were held, given in particular the limited presentation time afforded to each stakeholder, Mediclinic reserves its rights to make further submissions and looks forward to more engagements with the Panel.

¹ Dated 5 July 2018.
2 Facilities market concentration

2.1 Data and evidence

2.1.1 The evidence before the HMI establishes that the facilities market is not highly concentrated.

2.1.1.1 The HMI itself has now found that the beds-based HHI is 2,421 in 2017 and is below 2,500 every year between 2010-2017, thus it is a moderately concentrated market.

2.1.1.2 Medscheme, a large funder, showed in its presentation, using its own admissions data, that the facilities market is only moderately concentrated.

2.1.1.3 Netcare’s presentation illustrated that, based on the HMI’s own dataset underlying the Provisional Report, and even on the HMI’s own market definition, the correct HHI (based on beds) is below the 2,500 threshold for a highly concentrated market.

2.1.1.4 In any event, high concentration does not evidence market power, particularly so when no link between concentration levels and market power has been shown.

2.1.2 There is a trend of declining concentration in the facilities’ market.

2.1.2.1 There is agreement on this point by Mediclinic, Netcare and Life.

2.1.2.2 Netcare highlights in its presentation that the National Hospital Network ("NHN"), which has an exemption to, among other things, negotiate tariffs and procure collectively, has emerged as a fourth major national hospital group. Based on Netcare’s presentation, the NHN was able to grow its market share from 16% in 2010 to 25% in 2017.

2.1.2.3 Netcare and Mediclinic’s presentations showed that there has been significant entry by NHN and independent hospitals over time and especially since 2014.

2.1.2.4 Medscheme illustrated that the NHN are an important player, also in terms of acute beds which constituted 68% of NHN beds (March 2019). Based on Medscheme data, the NHN grew their market share from 18% to 21% (2014 - 2018).

2.1.2.5 Medscheme and Netcare also showed in their presentations that planned growth is largely from NHN and independent hospitals.

2.1.2.6 It is thus clear that the NHN is a significant fourth alternative and continues to be able to grow in the market.

2.1.3 There is no evidence of ‘must have’ status of hospital groups or ineffective bargaining power of medical schemes (DSPs/ networks and alternative reimbursement models ("ARMs")).

2.1.3.1 There is agreement on these points by Mediclinic, Netcare and Life.

2.1.3.2 The HMI itself finds that networks are pro-competitive,\(^3\) and that networks are increasing over time.\(^4\)

2.1.3.3 The Netcare and Mediclinic presentations included many examples of their facilities being excluded from networks.

2.1.3.4 Funders discussed the pro-competitive effects of networks.

2.1.3.5 Medscheme confirmed in its presentation that NHN has become a strong contender for anchor status on networks.

\(^2\) HMI Note of 2 April 2019, p18.
\(^3\) Provisional Report, pp 221 – 222.
\(^4\) Funder seminar note of 2 April, para 33.
2.1.3.6 GEMS, in its presentation, confirmed that DSPs have proven to be effective.

2.1.3.7 The Life and Mediclinic seminar presentations reiterated that the HMI under-reports ARMs. Netcare similarly submitted that the HMI's ARM data was outdated.

2.1.3.8 Funders and facilities generally agreed that funders already have sufficient market-based mechanisms by which they can and do discipline / constrain hospitals.

2.1.4 There is no evidence of facilities' excessive price increases or excessive profit levels.

2.1.4.1 This is the finding from the HMI's Provisional Report wherein the HMI confirms that profits are not excessive, and prices are closely aligned with CPI increases.

2.1.4.2 There is agreement on this point by Mediclinic, Netcare and Life.

2.1.4.3 Some funders have also indicated that there is no problem in terms of tariffs in the hospital market. Discovery, for example, showed that only 0,4% of 11% average annualised claims inflation increase over 2010-2018 is due to tariffs.

2.1.5 There is no evidence of over-utilisation or SID, as the HMI's local concentration study does not support these theories of harm.

There is agreement on this point by Mediclinic, Netcare and Life. This is further discussed in paragraph 4 below.

2.2 Findings and Recommendations

2.2.1 Mediclinic's Recommendations

To ensure a sustainable and more efficient and competitive private healthcare market, Mediclinic's proposed recommendations are listed below. These recommendations are generally useful improvements to the competitiveness and efficiency of the market; they are not based upon any evidence of competitive harm in the market.

2.2.1.1 It is essential that barriers to developing integrated delivery models such as HMOs, ACOs and IPAs, be removed. For example:

2.2.1.1.1 The Health Professions Council of South Africa ("HPCSA") ethical rules must be amended so as to be more permissive of group practices, global billing, and joint efforts to develop new care delivery models across the continuum of patient care. This would also facilitate contracting with the public sector.

2.2.1.1.2 There seems to be a misconception that the review of HPCSA ethical rules is only being advanced by facilities so as to allow for the employment of doctors; as apparent from Mediclinic's previous submissions, the concern rather lies with the inability to collectively develop innovative products and pricing mechanisms and for the healthcare system to operate in a less fragmented manner (employment of doctors only being one of many of the means to achieve the goal).

2.2.1.2 It is critical that the stability and viability of the medical scheme risk pool is ensured through regulatory reform, including:

2.2.1.2.1 enabling medical scheme regulation:

2.2.1.2.1.1 a risk-equalisation mechanism;

2.2.1.2.1.2 introduction of a standard basic medical scheme benefit package;

2.2.1.2.1.3 mandatory participation of formally employed;
2.2.1.2.4 the introduction of a risk-based solvency approach for medical schemes;

2.2.1.2.5 medical schemes to include primary care in their benefit packages enabling general practitioners to act as custodians of the healthcare of patients;

2.2.1.2.6 the introduction of a low-income medical scheme product;

2.2.2.2.7 Netcare confirmed that there is no support that the three hospital groups have market power or that concentration is increasing (instead it is declining) and there is already significant expansion by NHN and independent hospitals. Such drastic measures would result in substantial distortions and limitations on entry and competition and would have the unintended consequences of constraining hospital groups with the greatest potential to offer group-wide structures, new payment models and facilitate choices. Further that there is no empirical or other evidence for 20% as an ideal market share for any hospital group and the Competition Act identifies a presumptive dominance threshold of 45% (which higher share is in and of itself not a problem). The recommendations are thus unsupported and unnecessary.

2.2.1.3 In addition, Mediclinic supports, in principle, the following HMI provisional recommendations:

2.2.1.3.1 a tariff negotiation framework which allows the continuation of bilateral negotiations between funders and hospital groups for fee for service (“FFS”) and ARMs, although it is now apparent that the HMI may be proposing a form of multilateral tariff setting (see paragraph 3.2.1.2 below);

2.2.1.3.2 improved governance framework for medical schemes;

2.2.1.3.3 a pragmatic, standardised national framework for licensing of facilities;

2.2.1.3.4 strategic purchasing of private healthcare services;

2.2.1.3.5 enabling environment for contracting for value, i.e. to encourage the use of ARMs; and

2.2.1.3.6 health technology assessments or economic value assessments undertaken by an independent body using scientific and transparent methods which consider value and patient outcomes.

2.2.2 Discussion points

2.2.2.1 Netcare, Life and Mediclinic all take issue with the appropriateness, proportionality and effectiveness of the proposed divestiture and moratorium measures. In the absence of evidence of any theories of harm, it is agreed that such recommendations would fall short of the required standards of reasonableness and rationality.

2.2.2.2 By way of example only (and in duplication and amplification of what Mediclinic has previously submitted):

2.2.2.2.8 Life commented that divestiture or moratorium based on a national market share threshold has no basis in economic theory and there is no empirical evidence that a national share above a
certain level results in the ability to exercise market power. Should such a measure be imposed, hospital groups would actively be disincentivised to engage in competitive behaviour for fear of breaching the arbitrary threshold (when shares could well increase due to exogenous factors). If it is only 'solus facilities' that are to be divested, this will result in such alleged market power being transferred to the purchaser. Additional problems include: prospective purchasers could actually be less efficient (e.g. due to lower economies of scale), and the fact that forced divestiture may have a significant adverse effect on the facilities market insofar as it may disincentivise firms from competing in order to grow their market share.

2.2.2.3 There was broad consensus reached in principle that a standardized national licensing framework is required.

2.2.2.3.1 Licensing should account for the number of issued licenses granted, for both existing as well as planned capacity.

2.2.2.3.2 The facilities market requires an adequate repository of bed data to ensure the appropriateness of expansion.

2.2.2.3.3 Scope currently exists for facilities to interact with funders to ensure that expansion is appropriate.

2.2.2.3.4 Mediclinic supports the provisional recommendation that the role of implementation of the issuing of licenses is governed at the Provincial level.

2.2.2.3.5 Mediclinic is nevertheless still concerned with and opposed to various aspects of the licensing process proposed in the Provisional Report, namely the two-phase licensing application framework and the requirement of support from a predefined percentage of funders. Mediclinic has previously expressed its concerns with the practicalities of the former. Moreover, insofar as the latter is concerned, evidence was provided by facilities to demonstrate that funders have significant countervailing power and have the capacity to strongly influence licensing decisions of facilities.

2.2.2.4 The implementation of the granting of the Certificate of Need ("CON") in line with a centralized national licensing framework for all health establishments was not a seminar topic. However, to date there has been no evidence from the HMI or any stakeholder to suggest that a CON will be beneficial to facilitate access or improve efficiencies.

3 Funders market concentration

3.1 Data and evidence

3.1.1 There is no evidence of excessive price increases or excessive profit levels relating to facilities.

3.1.1.1 This is the HMI's finding in the Provisional Report.

3.1.1.2 There is agreement on this point by Mediclinic, Netcare and Life.

3.1.1.3 Price regulation is thus without foundation. There is no basis for concluding that prices are out of line or that funders and private hospitals cannot effectively negotiate prices.

3.1.1.4 Netcare indicated that price regulation would not address competitive concerns as the HMI itself concludes that prices are not excessive. Evidence indicates that prices are reflective of costs, and there is no economic study or evidence that the costs are at an inefficient level.

3.1.2 The tariff derived by a multilateral negotiation forum for facilities will be higher than that attained by bilateral negotiations.

3.1.2.1 This was highlighted by Life and Mediclinic, as well as Discovery.

---

5 Mediclinic response to the Provisional Report, dated 15 October 2015.
3.1.2.2 The HMI provides no evidence to show how purported benefits would outweigh the costs and unintended anticompetitive consequences.

3.1.2.3 It is Mediclinic’s view that current bilateral negotiations are robust, and the HMI has not put forward any tariff-based or other theory of harm to warrant such an invasive recommendation. In addition, there is no evidence of a ‘tariff vacuum’ in respect of facilities and funders’ tariff negotiations (see paragraph 3.2.1.2.2).

3.1.3 A multilateral negotiation forum for facilities will stifle innovation and efficiency.

3.1.3.1 Medscheme raised concern over innovation in the context of multilateral negotiations.

3.1.3.2 Mediclinic noted that innovation has increased since the Competition Commission ("Commission") outlawed collective bargaining. Should the HMI be concerned with the position of smaller funders and/or hospitals, an existing statutory remedy (amongst other existing market-based remedies), in the form of an exemption to negotiate collectively (as the NHN already enjoys), is available.

3.1.3.3 Discovery raised concerns regarding inefficiency, stating that the NHN's cost per event is higher than that of the other hospital groups. Since multilateral bargaining will likely result in NHN achieving a higher tariff, NHN will become materially more expensive for funders to contract with and would likely result in the unintended consequence of NHN being removed from networks by funders.

3.1.3.4 Netcare noted that there are provisions contemplated in the Competition Amendment Act which aim to protect small and medium sized enterprises and firms owned/controlled by historically disadvantaged persons from both price discrimination and buyer power, suggesting in light of such provisions, there is no need to resort to the drastic measure of multilateral tariff negotiations and regulated pricing.

3.2 Findings and Recommendations

3.2.1 Discussion points

3.2.1.1 The following points of consensus were reached during the seminar.

3.2.1.1.1 The HMI findings of no anticompetitive price or profits on the part of facilities, coupled with increasing evidence of funder countervailing power insofar as DSPs are concerned do not support the need for a multilateral tariff-setting mechanism for funders and facilities. This is further supported by increasing HHI measures within the funder market and decreasing HHI levels within the facilities market.

3.2.1.1.2 Funders expressed their concern with the recommendations regarding the introduction of regional schemes. Certain funders felt that this measure may lead to a deterioration of the incumbent scheme profiles.

3.2.1.1.3 A risk equalization framework is required, as well as a review of the solvency requirements applicable to medical schemes.

3.2.1.1.4 There was broad consensus reached that the standardised reporting and publishing of clinical outcomes is required. Facility stakeholders have made submissions to the HMI via the Hospital Association of South Africa setting out the possible components and recommendations in this regard. Facility stakeholders would however require explicit approval from the Commission to jointly collaborate to initiate the formulation and formalisation of this process and the Commission is requested to respond in this regard.

3.2.1.1.5 A review of the HPCSA ethical rules is required to foster greater levels of integrated care and alternative reimbursement models. Generally, stakeholders favoured the alignment of incentives as a better approach than hard-line market interventions.
3.2.1.1.6 A co-ordinated scientific approach to health technology assessments is in principle supported by stakeholders.

3.2.1.1.7 There is a need to review the PMB package and introduce greater primary care benefits to prevent unnecessary hospitalization and hospital-centric benefit structures.

3.2.1.2 There is neither evidence nor consensus supporting a multilateral tariff-setting mechanism or regulated pricing for facilities and funders.

3.2.1.2.1 Netcare, Life and Mediclinic, as well as some of the funders present at the seminars expressed the view that the current bilateral framework for facility negotiations is best suited to drive competition and innovation in the absence of an anticompetitive price or profits on the part of facilities, coupled with effective countervailing powers. The evidence shows that the current tariff negotiation framework between facilities and funders is competitive and robust.

3.2.1.2.2 The HMI itself conceded at the seminar that there was uncertainty in respect of the HMI's recommendation as set out in the Provisional Report and that many stakeholders had understood that they could opt out of the proposed multilateral tariff negotiations. On 10 April 2019, whilst the seminars were underway, the HMI clarified for the first time that it currently provisionally recommends multilateral negotiations be mandatory for all providers (doctors, other registered healthcare providers and hospitals) and funders. It appears moreover that the rationale for this recommendation is based on the perception that there would otherwise be a 'tariff vacuum' for some providers. The HMI has given no consideration to the complexity of private healthcare price setting and the associated costs of its proposal. It would be prudent for the HMI to understand the costs and unintended consequences prior to making such a recommendation.

3.2.1.2.3 On 12 April 2019 Mediclinic addressed correspondence to the HMI (a copy of which is attached as Annexure 1 hereto), the purpose of which was to obtain confirmation from the HMI that Mediclinic correctly understands the HMI's current recommendation in respect of bilateral and multilateral tariff negotiations and the proposed role of the Supply-Side Regulator for Healthcare ("SSRH") (if applicable), as per an explanation provided at the seminars. To this end, Mediclinic also asked further questions in respect of which it requested written clarification from the HMI. Mediclinic submitted that a reasonable level of detail must be understood at this juncture so that stakeholders can comment as to whether the proposal is sustainable and practically workable, and whether unintended consequences can arise. Mediclinic also requested that the HMI arrange a stakeholder seminar on this topic.

3.2.1.2.4 Whilst Mediclinic did receive a short response from the HMI to its 12 April 2019 correspondence, the requested clarity has not yet been provided and the requested seminar has not been confirmed. Save to reiterate that there is no evidentiary basis for such invasive recommendations which could have significant anticompetitive consequences, given the lack of clarity, Mediclinic is not in a position to prepare detailed submissions on the topic of multilateral price forums and regulated pricing. Mediclinic reserves its rights to make such submissions once the requested clarity has been provided. It is critical that the HMI benefit from meaningful stakeholder engagement on this topic prior to formulating its final recommendations.

3.2.1.2.5 There seems some consensus that the concept may be beneficial insofar as the tariffs of doctors are concerned, due to the practicalities of negotiating with numerous individual doctors.

4 SID and Overutilization

4.1 Data and evidence

4.1.1 There is no hospital-based SID theory or evidence.

4.1.1.1 The HMI in its initial research note on SID dated 10 July 2015 confirms that there is no hospital-based SID evidence ("In our search, the literature defined SID strictly as it relates to physicians and the servicing of patients. Thus, using our search terms and approach we identified nothing as applied to facilities and suppliers").
4.1.1.2 The HMI’s models conclude in the Provisional Report that there is no hospital-based SID evidence ("the supply of hospital beds was not that significant an explanatory factor in the specialty models")\(^6\).

4.1.1.3 This HMI repeats this in its Seminar Note of 4 April 2019 ("SID on the part of hospitals is understandably more remote")\(^7\).

4.1.2 The model utilized by the HMI contains various omitted variable biases, methodological flaws and a poor fit.

4.1.2.1 There is agreement on this point by Mediclinic, Netcare, Life, and SAMA.

4.1.2.2 The HMI confirms in the Provisional Report,\(^8\) its note of 4 April 2019, and the HMI’s seminar presentation that: a) their overall model fit was less than 8%, b) the bed data (and hence supply side variables) in the HMI’s specialty models are inaccurate; c) supply and demand are not able to be accurately studied within municipalities given that many beneficiaries travel beyond their municipality of residence for healthcare, and d) no causal link between supply and demand is analysed or established.

4.1.2.3 Discovery’s submission to the HMI and its presentation highlighted that the HMI’s models overstate SID and understate demand side drivers of utilisation, especially anti-selection.

4.1.3 The HMI’s international price comparisons do not account for all relevant factors and cannot be relied on.

There is agreement on this point by Mediclinic, Netcare, Life, and SAMA.

4.2 Findings and Recommendations

4.2.1 Mediclinic’s Recommendations

To ensure a sustainable and more efficient private healthcare market, Mediclinic’s recommendations, taking in account the HMI recommendations and as listed in Mediclinic’s presentation of 12 April 2019, are as follows:

4.2.1.1 removing barriers to develop integrated delivery models such as HMOs, ACOs and IPAs:

4.2.1.1.6 the amendment of the HPCSA ethical rules:

4.2.1.1.6.7 this will enable more cost and value centric care and innovative delivery models; and

4.2.1.1.6.8 will address fragmentation and unnecessary waste and aspects of fraud and abuse;

4.2.1.2 effective and accessible training facilities for nurses and doctors with scope for private sector training;

4.2.1.3 regulatory reform aimed at ensuring the stability and viability of the medical scheme risk pool, including:

4.2.1.3.7 a risk-equalisation mechanism;

4.2.1.3.8 introduction of a standard basic medical scheme benefit package;

4.2.1.3.9 mandatory participation of formally employed;

4.2.1.3.10 the introduction of a risk based solvency approach for medical scheme; and

---

\(^6\) Provisional Report, Chapter 8, para 58 page 400.

\(^7\) Para 10.

\(^8\) Chapter 8.
4.2.1.3.11 introduction of low income scheme product;

4.2.1.4 the industry wide development and introduction of a national grouper;

4.2.1.5 the establishment of an independent, neutral body to collect and publish reliable benchmark data on utilisation and quality indicators based on standardised definitions for the industry; and

4.2.1.6 health technology assessments or economic value assessments undertaken by an independent body using scientific and transparent methods which consider value and patient outcomes.

4.2.2 The HMI recommends controlling prices via SSRH (see paragraph 3.2.1.2 above), but this does not flow from SID analysis, which is a non-price theory of harm.

4.2.3 Discussion points

The following points were discussed during the seminar.

4.2.3.1 Funders expressed their concern with the recommendations regarding the introduction of a single tier base benefit package. Consensus was not reached on this measure; however, it was suggested that the base benefit could potentially be tiered to allow for greater affordability and sustainability. The base benefit package should not be introduced at the expense of scheme sustainability.

4.2.3.2 A risk equalization framework is required to ensure sustainability of the medical scheme risk pool.

4.2.3.3 Mandatory membership should be reconsidered by the HMI as its introduction will drastically reduce premium cost and expand access to coverage. There will be both a short- and long-term improvement in affordability (a significant improvement in affordability will occur initially as membership increases, with long term affordability continuing to improve more gradually as the risk pools of medical schemes improves over time).

4.2.3.4 The HMI’s findings do not support interventions as they pertain to facilities, nor are these findings a price-based theory of harm to support recommendations for price control through a SSRH.

We trust that this is of assistance.

Please do not hesitate to contact us to discuss.

Yours faithfully

ANDRE DE LANGE / SUSAN MEYER
CLIFFE DEKKER HOFMEYR INC