SEMINAR
Funders’ market concentration and countervailing power

20 February 2019
INTRODUCTION

1. This note briefly sets out the background, purpose and objectives of the HMI’s seminar on funder concentration, countervailing power of medical schemes and interventions to take on the 20th February 2019. The seminar will take place following immediately from the Facilities’ market concentration seminar on the 19th February 2019. These seminars are interconnected and some of the discussions will be overlapping.

2. In July 2018, the HMI published its provisional report. The report contains an analysis of the medical schemes’ (Chapter 5.1) and administrators’ (Chapter 5.2) markets. The report also discusses the existence and effects of national and local market concentration with respect to the facilities market (in Chapter 6). The provisional recommendations intend to strengthen the countervailing power of funders as agents for consumers to counteract what the HMI considers to be a concentrated facility market (Chapter 10, par. 68-83).

3. Stakeholders have responded in written submissions to the HMI’s provisional report with varying degrees of both support for and disagreement with the proposed recommendations. A number of submissions noted the disparity between the proposed recommendations targeted at concentration in the facilities’ market and those aimed at dealing with concentration in the funders’ market. In particular, the HMI did not propose constraining the market shares of the dominant schemes and/or administrators.

4. Here we outline, at a high level, the findings and recommendations relevant to this seminar. Detailed views expressed in the latest round of submissions by different stakeholders are available on the website at the following link.

HMI FINDINGS ON CONCENTRATION AND COUNTERVAILING POWER

5. The HMI’s findings and proposed recommendations for the funders’ markets can only be appreciated when seen in the context of the HMI’s findings on concentration on the supply side of the market. The HMI, during the course of its investigation, found that the facilities’ markets exhibit substantial levels of concentration at both national and regional levels (Chapter 6).

6. To summarise, the HMI found that the three large hospital groups have a substantial share of the national general acute hospital care market based on both admissions and registered beds with HHIs in the range of 2500. These HHIs are considered internationally to be an indication of a highly concentrated market. Acknowledging that negotiations take place at the national level, these national concentration levels provide a significant strategic advantage in bilateral negotiations to the three largest facility groups – both individually and as a collective. Nationally operating schemes/administrators cannot avoid contracting with any of the three big hospital

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1 Available online at: http://www.compcom.co.za/provisional-findings-and-recommendations-report/
groups. Evidence of singular hospitals excluded from particular networks at a local level do not alter that conclusion. Negotiations take place nationally; not locally. Each of the three nationally operating hospital groups are effectively a must-have to each of the nationally operating schemes.

7. At a local level, the HMI using HHI as an indicator, identified 113 facilities (out of a total of 195) to be in concentrated local markets. Making use of the LOCI approach to concentration, the HMI identified 114 facilities which it considers to be in concentrated local markets. This is sufficient to conclude that more than half of South Africa’s local facilities’ markets are considered to be either concentrated or highly concentrated.

8. Furthermore the HMI has found that doctors in South Africa, unlike in many other countries, are not employed by facilities and most specialists actively resist inclusion in schemes’ designated service provider (DSP) networks. There exists a mutually beneficial symbiotic relationship between facilities and medical specialists: if doctors admit to hospitals, hospitals benefit. Funders’ actuarial solution of providing “hospital plans” exacerbates this problem. The doctors’ ability to admit and provide care which is over and above the level that is cost-effective benefits both the hospital and the practitioner. Neither hospitals nor practitioners have an incentive to limit treatment or utilization to the appropriate level.

9. Further, as is well understood, in a third-party payer healthcare system, individual patients and beneficiaries are not incentivised to resist overuse and overtreatment which is compounded by information asymmetry. Despite the growing importance of DSPs in the South African market, the HMI’s findings suggest that facilities and doctors are not currently disciplined by the countervailing power these and other tools provide schemes and administrators.

10. The HMI’s preliminary report has shown evidence of excessive utilisation and supplier induced demand in Chapter 8, and of possible links to market concentration in Chapter 6, par. 376 – 392. The HMI is organising a separate seminar to address the complex phenomenon of supplier induced demand on Friday 22 February 2019.

**FUNDERS’ MARKETS AND ROLES**

11. The HMI makes a distinction between two separate effects of concentration in the funders’ market.

- Funder concentration has an impact on the downstream market in providing coverage and services to beneficiaries in South Africa. Briefly put, the more market power a company has, the more shielded it is from competitors, and the easier it gets for such funders to ignore the real interest of beneficiaries and patients, and to put shareholders’ interests before clients’.

- The upstream market is where a funder buys its products and services for its clients (schemes and beneficiaries). Bargaining power allows the funder to get the best deal (based on volume, cost and quality) for medical scheme beneficiaries. However where
there is not sufficient competition, then funders are less inclined to discipline providers; hospitals and doctors alike.

12. The structure of the funders’ (schemes and administrators) markets is considered to be concentrated. In the open medical scheme market, the C3 ratio is 75%, of which Discovery Health Medical Scheme (DHMS) on its own has a market share of approximately 55%. Similarly in the restricted medical schemes market Government Employees Medical Scheme (GEMS) has a share of 47% and South African Police Service Medical Scheme (POLMED) is the next largest with 13%.

13. In the open medical scheme market, both the high and growing level of market concentration and DHMS’s high and growing share in it, merits discussion. In the open scheme market, the HHI index developed over time from 1510 in 2005 to a highly concentrated 3391 in 2016. The HMI is concerned by these figures. As noted above, on the one hand, the bargaining power of schemes needs to be substantial in order to counteract the bargaining power of strong players on the supply side of the market. In this regard, the HMI has found evidence of degrees of countervailing power possessed by the large schemes (see bargaining section in Chapter 6).

However, on the other hand, the HMI is concerned about further concentration of the open schemes market and DHMS’s share in it. Likewise in the restricted medical scheme market, concentration will increase further as a result of the planned consolidation of all government related schemes into GEMS. The question is, from a competition point of view, whether these high and growing levels of concentration may lead to lower levels of competition and/or responsiveness to beneficiaries needs, with schemes turning more self-centred and complacent and less inclined to use buying power to discipline providers and mind the interests of clients in the upstream markets.

14. In the administrator market the situation is more complex but a similar pattern emerges. Depending on the definition applied, the three larger administrators: Discovery Health (Pty) Ltd, Medscheme Holdings (Pty) Ltd (Medscheme) and Metropolitan Health Corporate (Pty) Ltd (Metropolitan Health) constitute around 80% of the market, with Discovery Health having a market share of 40%. The market has seen no significant and sustainable entry in over a decade and Discovery Health has won all but a few tenders for the administration of schemes that wish to change administrators. This has resulted in Discovery Health growing its market share to a higher proportion and at the same time consistently earning significantly higher profits than its main rivals.

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2 See Provisional report Table 5.1 pg. 80
3 See Provisional report Table 5.2 pg. 82
5 HMI provisional findings report, pg. 133, Table 5.5
15. Findings on the upstream market were that funders, in their role of procuring services, are not performing optimally. Procurement of healthcare services should focus on reducing costs for patients and beneficiaries of schemes, while certifying quality of care and stimulating and rewarding innovation in healthcare service delivery. The current negotiation between funders and service providers however is largely limited to prices and terms and conditions of DSP inclusion (which also largely focus on price).

16. Funders are failing the consumer by not putting enough pressure on the industry to innovate, to manage overutilization and to provide demonstrable quality and improve health outcomes. There is little focus on the overall value of services purchased.

17. Risk transfer, like ARMs, are still in their infancy in South Africa – despite the number of contracts claiming notional ARM arrangements. These ARM contracts typically have large carve outs which prevent effective risk transfer. In the case of doctors, HCPSA’s ethical rules are often cited as barriers to effective risk transfer agreements and to innovative care models, however there are instances where innovation has occurred in spite of this. This raises the question of whether doctors, at times, may use ethical rules as a convenient excuse. DSPs, despite the growing numbers of hospitals and doctors under contract, do not appear to be able (yet) to alter what the HMI’s provisional report has called ‘perverse’ effects of local competition for doctors by hospitals at the local level.

18. In sum, on the procurement (upstream) side, funders can and must improve. The current efforts still largely appear to fail the consumer.

19. Findings on the downstream market are:
   - Trustees and principal officers of medical schemes do not have sufficient incentives to act as agents for members of their schemes. Members are unable to hold contracting parties (administrators, and MCOs) to account. CMS, the funder industries’ regulator, while reportedly understaffed, has been unable to make up for this flaw in the governance structure.
   - The unique and somewhat artificial delineation in South Africa of medical schemes as non-profit organisations and medical scheme administrators/MCOs as for-profit partners is problematic. There is no real evidence of competition which would be seen through lower contribution premiums and richer benefits among the 22 open medical schemes. Although this is a factor of some importance in tendering processes, administrators have no clear incentive structure that aligns the interest of beneficiaries to their own commercial interests. The financial interests of shareholders and of the financial groups these administrators are accountable to, appear to trump the interests of beneficiaries under administration.
   - As the services and products of medical schemes are generally complex, lack transparency, and are not standardised they cannot realistically be compared on value for money by anyone. This includes a comparison by the professional agents representing the
consumer, i.e. the broker or the healthcare practitioner. Competition between open medical schemes tends to focus on risk selection (i.e. for younger and healthier members) and avoiding paying out of risk funds. Ideally, competition should be on optimizing service to the beneficiary against the best possible price.

**TOPICS / QUESTIONS**

20. For practical reasons and in order to organise a focussed seminar, we have formulated a number of questions. The HMI invites stakeholders to make additional relevant agenda suggestions to the HMI before the 31st of January 2019 alongside their confirmation to attend to the seminar. The HMI proposes that the seminar addresses the following topics:

- Will the HMI’s proposed recommendations, for example the stand-alone, standardised, obligatory ‘base’ benefit package that all schemes must offer, and other regulatory interventions aimed at aligning schemes and administrators interests to beneficiaries have the effect of reinforcing the countervailing role of funders and re-align funders interest to beneficiaries interests? If not, what more should be done?

- The uneven distribution of market shares in the schemes’ and administrators’ markets and the unchallenged dominance of DHMS and Discovery Health in these areas is of some concern to the HMI. In a market-led environment, stakeholders should be exposed to competition in order to perform optimally for the benefit of the consumer and for the industry to remain competitive in the long-run. The HMI is interested in hearing if its recommendations could be augmented to achieve this. Will measures such as levelling the playing field for administrators – either allowing them all to negotiate collectively on behalf of all of their non-competing schemes, or to forbid them all from doing this be advantageous for consumers? What other structural measures are missing?

- DSPs are starting to be a relevant factor in South Africa. DSPs can be effective in dealing with health care delivery inefficiencies at the local level, even in reversing what the report found to be perverse outcomes of local facility competition. Is there evidence that DSPs are delivering on this promise? What can be done to make them more effective? Would it be advisable for all providers to be obligated to opt in to some kind of ARM or DSP as a matter of course? Would making the issuing of practise numbers or licences dependent on this be practicable and effective?

- The false divide between not-for-profit schemes and for-profit administrators in South Africa is problematic and disturbs incentive structures and alignments of interests between members, trustees of schemes, administrators / MCOs. The HMI has considered but has avoided making recommendations that change for-profit and not-for-profit orientation of the

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6 See chapter 10 of the HMI’s Provisional Report for a more in depth look at the proposed recommendations, pg. 457 - 462
industry. However, the University of Fort Hare submission has proposed legal measures to impose fiduciary duties on administrators in order to align the interests of administrators to the interests of the schemes under administration, and in particular to the interest of its members. Here is the link to the University of Fort Hare’s contribution for convenience. Is this a solution? What other solutions exist?

CONCLUSION

21. The HMI is aware that stakeholder buy-in is an important facet in ensuring recommendations are effective in both implementation and in achieving the intended purpose. As such, the HMI welcomes this opportunity to engage with all stakeholders affected by the proposed recommendations regarding the funders market.

22. It must be highlighted that the HMI is not requesting any further written submissions but rather requests responses be through presentations and debate at the seminar. As such, the HMI welcomes any stakeholder who wishes to make a presentation to reply in an email if they desire to do so, providing a brief summary of its content. The HMI reserves the right to select the final presenters based on the submissions received. Presenters will be notified to coordinate content and time slots. The format and list of speakers will be furnished to attendees at a point in time closer to the date of the seminar.

23. This is an invitation to attend the HMI seminar on the funders’ market concentration and countervailing power at the HMI’s offices on 20 February 2019. Please RSVP no later than 31 January 2019, at healthinquirydirector@compcom.co.za

Please include any additional subjects to be discussed and provide a summary of your presentation if you intend to present.