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Health Market Inquiry

Promoting Healthy Competition

SEMINAR

Facilities' market concentration and remedies

19 February 2019

INTRODUCTION

1. This note briefly sets out the background to the purpose and objectives of the HMI hosting a seminar for stakeholders on facility concentration and interventions on the **19 February 2019**.

2. In July 2018, the HMI published its Provisional findings and recommendations report.[1] Amongst the topics discussed are the existence and effects of national and local market concentration with respect to the facilities market (in Chapter 6). The report also contains provisional recommendations intended to address current and possible future effects linked to what the HMI considers to be overly concentrated facility markets (in Chapter 10, in particular paragraphs 68-83).

3. A number of 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. The purpose of this seminar is for the views of stakeholders to be expressed, and to provide the HMI panel with inputs and clarity as to the appropriateness of the recommendations.

4. This note outlines the findings and recommendations relevant to this seminar, provides a high-level overview of the analyses which were used to reach these findings. Full submissions from stakeholders are on the HMI's website for attendants to consult. **http://www.compcom.co.za/12138-2/**

HMI FINDINGS ON CONCENTRATION

5. The HMI, during the course of its investigations, identified that the facilities market exhibits substantial levels of concentration at both national and local levels. These findings are in Chapter 6 of the provisional findings report and are only briefly repeated here.[2]

6. Specifically, the three large hospital groups were found to have a substantial share of the national market based on both admissions (90%) and registered beds (83%), and HHIs in the range of 2700 and 2500 respectively. Some stakeholders have criticised our inclusion and exclusion of certain hospitals in these calculations, the bed numbers used, as well as the time period over which the analysis was conducted (up to 2014). Several submissions have offered alternative calculations to come up with decreased market shares and HHIs.

7. At a local level, the HMI made use of several different metrics to determine the relevant markets as well as several different measurements to determine concentration. The individual hospitals which the HMI found to operate in concentrated markets were largely consistent with the analyses done by the facility groups themselves, although the HMI did identify a number of additional concentrated hospital markets. The HMI, using HHIs as an indicator, identified 113

[1] Available online at: http://www.compcom.co.za/provisional-findings-and-recommendations-report/
[2] See chapter 6 of the HMI's Provisional Report for greater detail on the HMI's findings and conclusions regarding concentration and its effects on the healthcare market.

concentrated local markets out of a total of 195, while the LOCI approach to concentration identified 114. The similarity in results derived from these very different methodological approaches and similar conclusion from a range of stakeholders, is reassurance that the results are robust enough to base the discussions on in the upcoming seminars. All players agree that the facilities market is concentrated; the degree of concentration seems to be a point of contention.

8. The HMI is of the opinion that these national concentration levels provide a significant strategic advantage to the three largest facility groups – both individually and as a collective - in the national bilateral negotiations. Schemes/administrators which operate nationally cannot avoid contracting any of the three big hospital groups. The hospital groups to a significant degree are a must-have. Medscheme, to give an example, must necessarily contract with each of Life, Mediclinic and Netcare. This dynamic provides the three hospital groups, both individually and collectively, with a significant degree of power. The HMI has heard stakeholder views but is of the opinion that evidence of singular hospitals being shut out of particular networks at a local level do not alter that conclusion. Negotiations take place nationally; not locally.

9. The HMI has also concluded that structural, behavioural, and regulatory barriers to entry are not prohibitive. As noted by stakeholders with which we agree is that entry by new hospitals has happened over the observed period. However, the entry and expansion which has been observed over the relevant period has had limited impact on the current competition dynamics.

10. As to profitability of the big three hospital groups, profitability results have been and still are rewarding. When considering the profitability of the three main hospital groups together, we conclude that the groups have consistently increased their profits over the observation period, with the last five years seeing the return on capital employed levelling off to between 21 and 22% on average (against a weighted costs of capital of 16.5/16.6%).

11. In addition, the HMI has concluded that significant levels of inefficiencies, in the form of over-utilisation and supplier induced demand exist in the South African market. This is the subject of a seminar on the 22nd of February. While the HMI acknowledges that medical practitioners are primarily responsible, hospital groups nevertheless derive substantial profit from this behaviour and therefore lack any incentives to address this issue.

12. The HMI has concluded that the impact of local market dynamics is linked to varying degrees of market concentration resulting in varying but significant degrees of inefficiency. Hospitals compete for doctors at the local level. This includes providing incentives to work at their hospitals by offering low rental for doctor's rooms, covering costs of moving from one hospital to another, provision of particular services such a cath-labs) better hotel services, access to a large number of beds (meaning that there is seldom a point where there not a bed or a high level care bed should a doctor want to admit a patient), covering of start-up costs and

guaranteed income[3], assistance with and in some cases access to technology. This creates inefficiencies which have not been offset (yet) by the countervailing bargaining power of administrators/schemes through the use of effective DSP and ARM arrangements to discipline cost-inefficient providers.

13. An important question for the seminar is whether DSPs in some of the local South African markets are managing to reverse what the report called 'perverse' competition at the local level. Are we beginning to see more orthodox and positive results of competition where lower levels of concentration and intensified competition leads to lower prices, less inefficiency, more consumer-orientation and innovation? Although networks have been seen to be becoming a more common feature in the market, the unrivalled ability for network options to foster greater price competition amongst facility groups begs the question as to why it is not a ubiquitous feature amongst schemes. This later point will be discussed at the Funder concentration seminar.

14. Alongside networks, concerns have also been raised regarding how national and local concentration provides facility groups with the ability to frustrate the effective implementation of ARMs. Hospital groups dispute this by claiming ARMs account for a substantial proportion of revenues. However ARMs are a broad category and whether substantial risk transfer occurs under these models is less clear. It appears that carve-outs tend to invalidate risk transfer. Further, it is claimed that schemes have countervailing power to opt in or out of ARMs. Anecdotal evidence disputes this and shows that the overall costs of hospital driven ARMs, in some circumstances, is greater than the FFS model equivalent. True countervailing power would be the ability for schemes to implement effective ARMs which incentivise and stimulate providers' responsibility for cost- effective treatments.

15. As stated, the HMI has noted that some of the stakeholders, in particular some of the hospital groups, have provided alternative facts and figures around the level of national market concentration in the facilities' market. The HMI is not ignoring this. It will not be fruitful to burden the seminar with a highly technical and sometimes cumbersome discussion about varying numbers of beds and admissions, what type of hospital is in or out of the relevant market, etc. We reiterate that all the stakeholders agree that there is concentration in the facilities market at national and local level.

16. The HMI seeks stakeholder view on the provisional report recommendations, i.e. what can and should be done to protect the interest of consumers.

17. For this seminar the HMI will focus the discussion on the impact of concentration on negotiations. For example our finding that tariff negotiations revolve predominantly around the degree to which tariffs increase will be at or below CPI, some discussion on network adoption

[3] This is more so for casualty services

but less so bargaining around effective ARMs to control utilisation or quality. *The role of funders in this will be the subject of a separate, connecting seminar on funders' market concentration and countervailing power on the 20th of February 2019.*

RECOMMENDATIONS

18. In order to address the concerns raised in the provisional report, the HMI has put forward a number of preliminary recommendations.[4] Notably, these include developing a coordinated licensing framework, notifying competition authorities when licences are transferred, a review on merger guidelines as they relate to facilities, a discussion on the proportionality and effectiveness of divestiture and/or imposing a moratorium on licences to the three large hospital groups.

19. The HMI has recommended that the provincial licensing regime needs to be coordinated. Specifically, that the Certificates of Need provisions of the National Health Act are granted in line with a centralised national licensing framework. This national framework should take into account public and private capacities, diversity, access, and prioritising innovative care. In addition, licences should come with mandatory reporting conditions in order to address the lack of a reliable and consistent health facility database. Finally, the sale or transfer of ownership of these licences should be notifiable to the Competition Commission and an assessment should take place as would occur in merger review.

20. The licensing framework is a forward looking measure but one which does not address the immediate concentration concerns. The first intervention proposed to address this concern is a moratorium on licences to the three largest groups, until such time as the national market share, by bed numbers, is no more than 20%. The recommendations also table divestiture as a possible means to address immediate concentration concerns, and proposes to discuss with stakeholders the proportionality and effectiveness of these interventions.

21. However, the HMI is mindful that both measures will need to be proportionate to the harm identified and needs to consider whether less interventionist means may achieve similar outcomes. Proposals in this respect are welcomed.

22. In response to the findings and recommendations outlined above, HMI has received substantial feedback from stakeholders in the form of written submissions. These submissions are available online and participants to the seminar are encouraged to consider the views contained therein.[5]

[4] These recommendations are only briefly addressed here. See chapter 10 of the HMI's Provisional Report for a more in depth discussion of the proposed recommendations
[5] Available online at: http://www.compcom.co.za/healthcare-inquiry/

23. The responses by hospital groups have provided valuable input on the HMI's analyses and while some of the details will be updated, the general finding that the market is concentrated is accepted by all. This concentration in the facilities market, both currently and moving forward, are likely to remain a concern. We acknowledge that facility groups have indicated concerns with the HMI's findings but we are in particular interested on their opinions on the remedies put forward to address the overly concentrated markets in SA.

24. While the responses from funders on this topic have generally supported the findings, responses to this topic have nevertheless been rather limited. As any measure which impacts the facilities market will have an impact on the rest of the healthcare market, the HMI wishes to encourage all funders to participate in the seminar.

SUMMARY DISCUSSION POINTS

- The main findings relate to national and local concentration. The HMI has further found there to be limited entry and innovation, and models of delivery, while hospital group profitability results have remained consistent. There has been limited effective risk transfer amongst the majority of ARMs and DSPs have done little to reverse what the HMI called perverse levels of local competition amongst local hospitals.
- In terms of recommendations, the HMI has proposed changing the licensing regime, stimulating the prevalence and effectiveness of DSPs (HPCSA's ethical rules, outcome registration), the possibility of divesture and freezing the market share of main hospital groups.

CONCLUSION

25. 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 around facility market concentration.

26. This seminar is focused on the recommendations.

27. It must be highlighted that the HMI is not requesting further written submissions but rather requests responses be through presentations and debate at the seminar. As such, the HMI invites stakeholders who wish to make a presentation to email their draft presentation to The HMI before **31 January 2019.** The HMI reserves the right to select the final presenters based on the submissions received. This will be to allow for a range of opinions and is not intended to shut out any contribution; it is just that where presenters are saying the same/similar things it is not a good use of time to allow for repetition. The HMI will contact presenters 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.

28. **This is an invitation to attend the HMI seminar on the facility market concentration and interventions at the HMI's offices on the 19th of February 2019. Please RSVP no later 31 January 2019, at** healthinquirydirector@compcom.co.za