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HMI Seminar: Facilities Market Concentration and Remedies

Presentation to the Health Market Inquiry

Prof. Nicola Theron, 9 April 2019

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Context and Approach

Point of departure of seminar

- Context – HMI Recommendations and Rationality Imperative (Adv Michelle Norton SC)
- Purpose of the 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
- No evidence on alleged anti-competitive effects
- HMI Seminar Note: *"All players agree that the facilities market is concentrated; the degree of concentration seems to be a point of contention"*
- Mediclinic view is that national market is not highly concentrated, but moderately concentrated; there is also a trend of declining concentration
- Important distinction, as principle is well established that remedies should be proportional to the harm identified (recognised by the HMI)
- HMI Terms of Reference (November 2013), Aim of the Inquiry: *"… provide a factual basis upon which the Commission can make evidence-based recommendations"*
- Without accurate and reliable evidence, focus on remedies is premature
- However, Mediclinic will provide views on alternative and less interventionist measures as requested by the HMI

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Main findings: Facilities market concentration

Review of methodology and dataset used

National concentration study

1) **Basic inaccuracies in calculations**,
2) **Exclusion of facilities to create narrow dataset**,
3) **Outdated data**

National market shares lower than those presented by the HMI

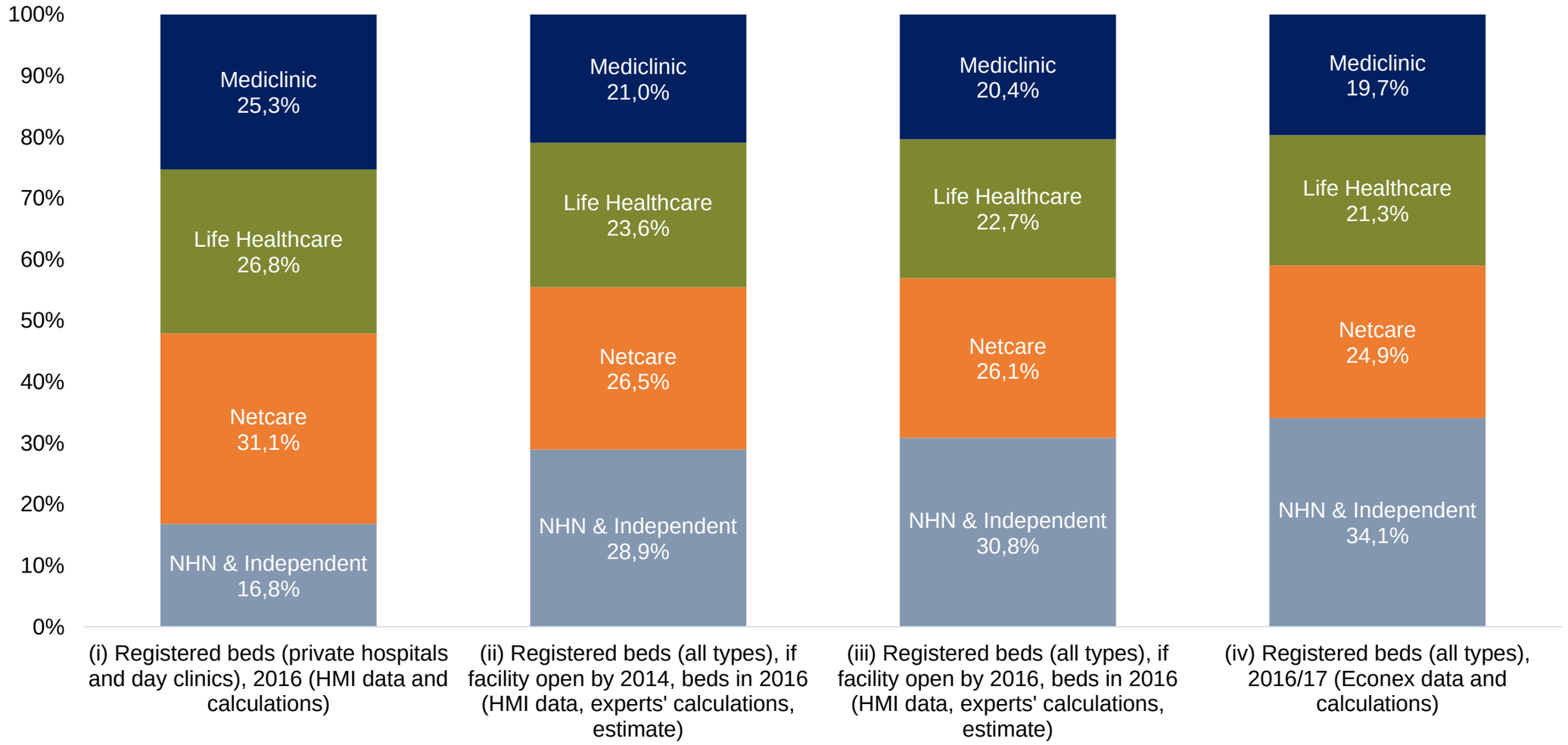
- Based on admissions, Netcare, Life and Mediclinic jointly have 76% share in 2014 (the HMI finds 76% (only 2014) and 90% (2010-2014), dependent on its sample)
- Based on beds, Netcare, Life and Mediclinic jointly have 66% in 2016-2017 (HMI finds 83% in 2016)

National HHI's are lower than HMI's

- Based on admissions, the HHI is 2210 in 2014; based on beds, the HHI is 2183 in 2016 (neither are close to or above 2500)

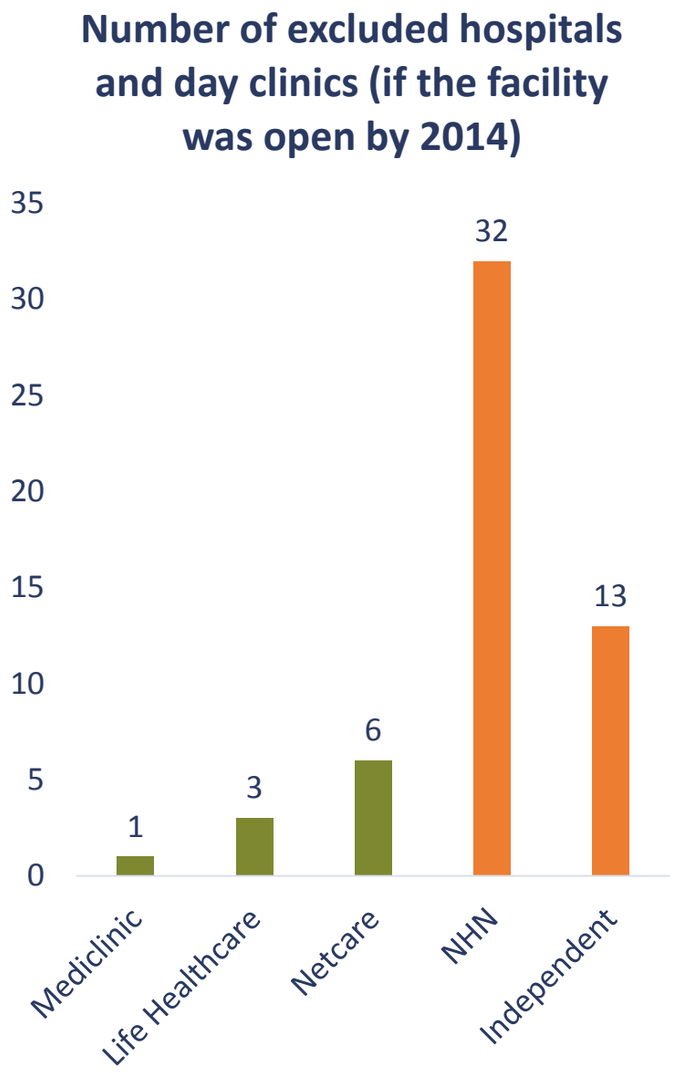
58% of acute beds added over 2014/5-2016/7 are NHN/Independents

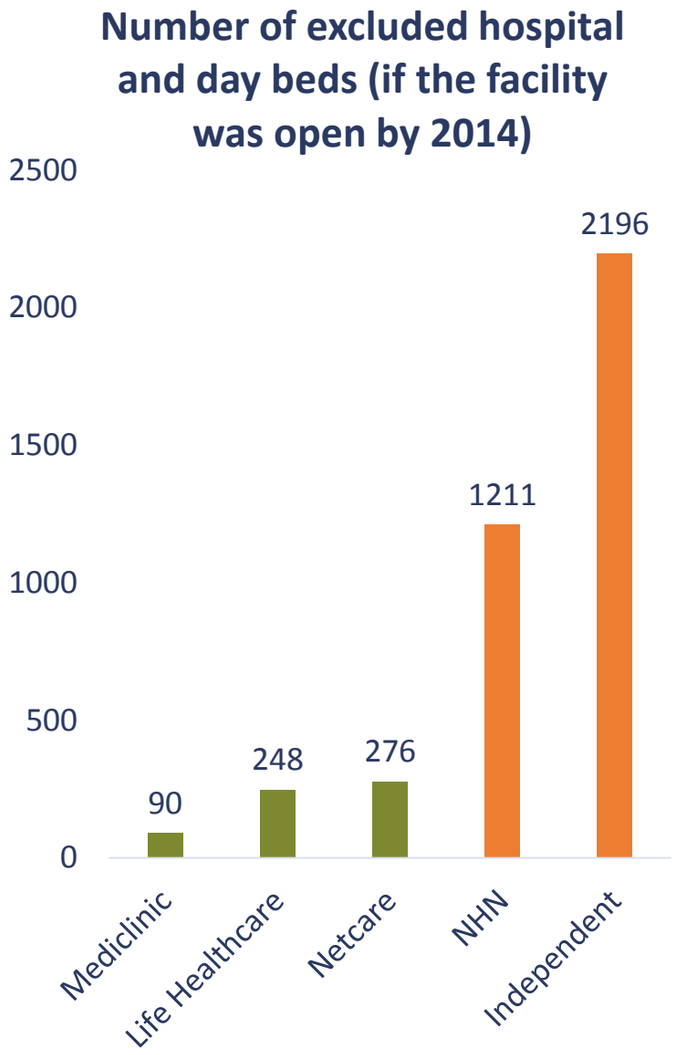
Once these concerns are addressed, the market is no longer ‘highly concentrated’
Beds (HHI = 2 183)



Effect of exclusion of beds/ facilities – skewed against 3 large groups

3407 NHN and independent beds excluded from analysis, but only **614 from Mediclinic, Life Healthcare and Netcare together**, artificially lowering the NHN and independents' market shares and increasing the market shares (and hence concentration) of the 3 large groups





Outdated data, new entry and effect on concentration

Correcting for entry post 2014

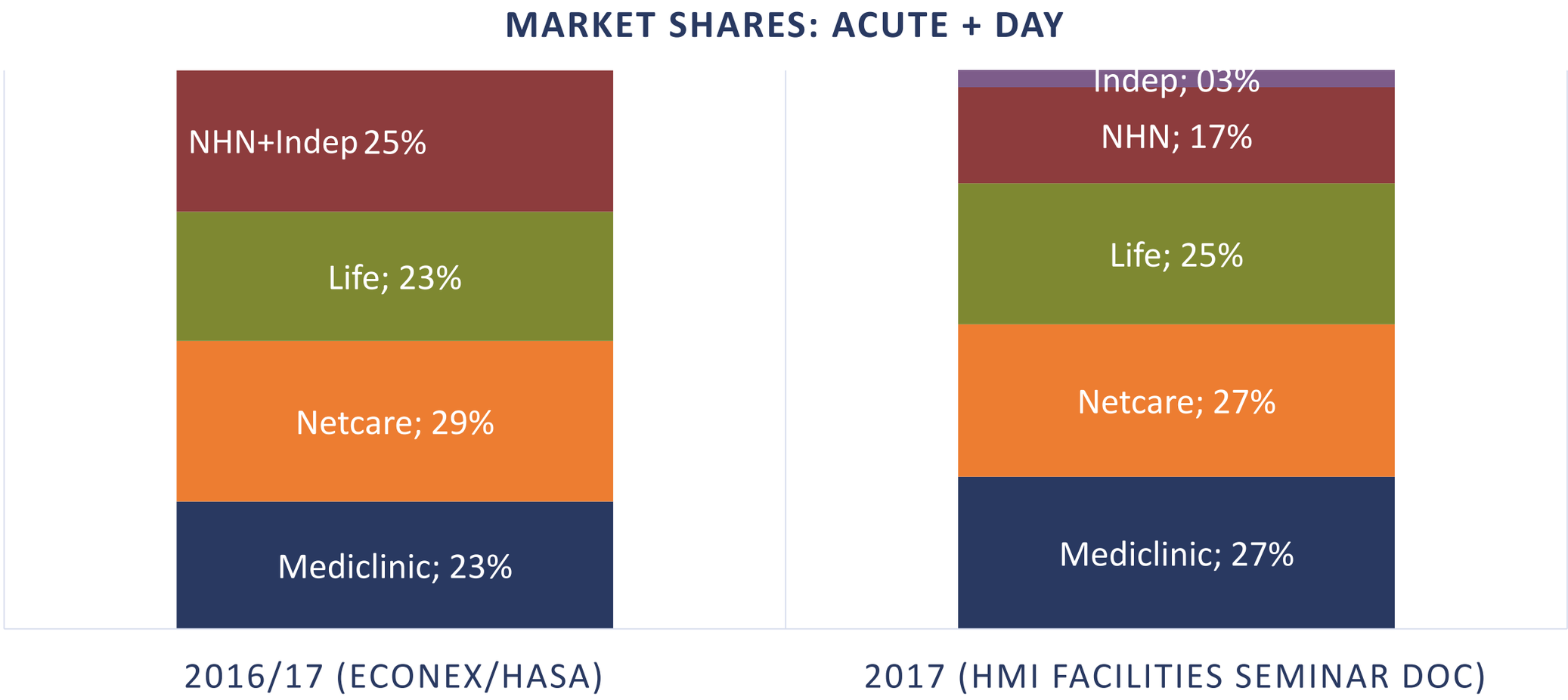
Ownership / Classification	Change in acute beds (2014/15 to 2017/18)
Beds in known* new NHN/independent hospitals and expansions	**1297**
Life Healthcare	306
Mediclinic	185
Netcare	455
LHC, Mediclinic, Netcare	**946**

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; this is not considered in the HMI's analysis

** Likely an underestimate.*

New analysis by the HMI – April 2019

HMI New data brings the HHI down to 2 372.



Local market concentration - Review of methodology

Local concentration study

Main finding by the HMI: more concentration leads to more competition

Study sample is 12% of regions (24/ 195) – 6 Mediclinic hospitals in final sample

Conclusions 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

When analysis run on all regions, results are no longer valid – the sample is therefore not representative

Reliance on EA’s, HMI has recognised problems;

Phase 3 local concentration market studies not published;

Concentration = better competitive outcomes?

Actual minus expected admissions

HMI (Broad disease indicator) – based on sample (12% of regions). Provisional Report only narrow indicator

Actual minus Expected	2010	2011	2012	2013	2014
Concentrated	-8.12%	-9.62%	-10.18%	-8.20%	-8.79%
Moderately Concentrated	10.20%	9.71%	10.43%	10.20%	9.45%
Non-Concentrated	3.94%	3.14%	3.74%	4.68%	5.78%

Econex recalculated (based on all regions) - the local concentration results (admissions) do not hold once all regions are included

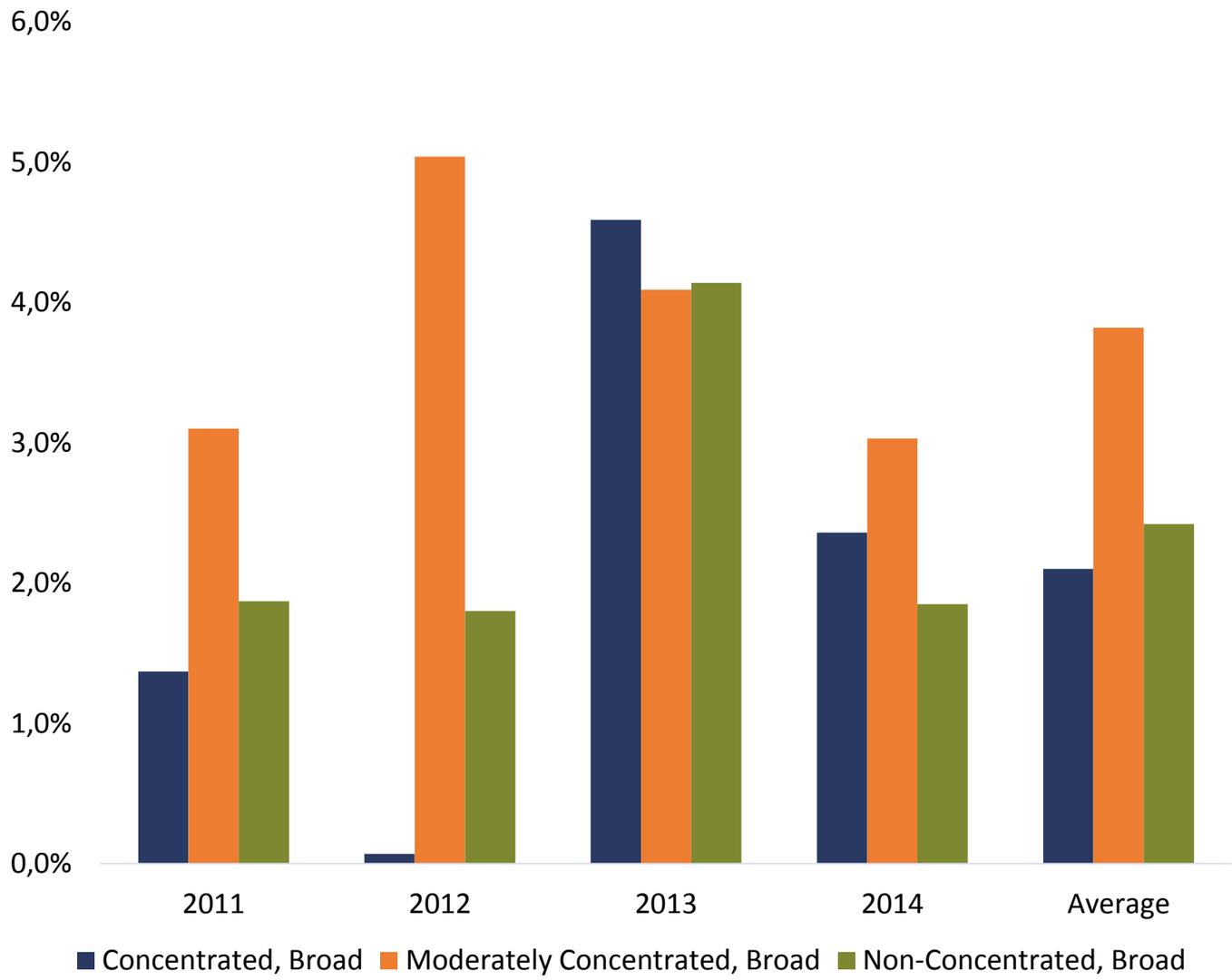
Actual minus Expected	2010	2011	2012	2013	2014
Concentrated	-0.17%	-1.17%	-0.63%	-0.12%	0.37%
Moderately Concentrated	-0.11%	-1.34%	-0.85%	-0.56%	-0.35%
Non-Concentrated	0.02%	-1.03%	-0.47%	0.09%	0.59%

Local concentration and over-supply – expenditure

Results and fundamental flaws

In-hospital claims, unexplained increases, broad disease indicator, 2011-2014

No consistently higher trend in unexplained increases to support the hypothesis that more competitive markets yield inefficiencies and higher than necessary costs



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Theories of Harm

Excessive pricing and excessive profits - no evidence

Prices

No price theory: *"Overall, 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)."*

HMI (only remaining) price theory: *"When assessing the tariff increases, these appear to be marginally within the CPI increases. It may therefore be misconstrued that tariffs have been increasing within acceptable ranges. However, the Inquiry remains concerned about the initial base price from which increases were calculated, since the base price was still linked to the collusive outcome."*

Profits

"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."*

"As noted, the Inquiry recognizes that it needs to view the outcome of the profitability analysis calculations within a reasonable degree of tolerance in the context of the Inquiry. This is to cater for the comparison of ex post performance against ex ante WACC, differing methodologies and assumptions in the revaluation of assets by each of the relevant firms, inclusion and valuation of intangible assets and entity specific risk factors to name a few."

National Bargaining Theories of Harm

ARMS

25% of Mediclinic admissions (not 6-7% as measured by the HMI)

Not automatic preference by funders; take-up often beyond provider's control

DSPs

- Overall aim of networks is to reduce cost by channeling volumes to network hospitals;
- Restriction of member choice results in lower cost to scheme;
- Volume is the mechanism used by schemes to obtain a discount from hospitals;
- Hospitals want to be on as many networks as possible to gain from increased volumes;
- Schemes design networks strategically to serve their own goals;
- The three large hospitals groups are not must-haves, as there are currently networks without their hospitals;
- The NHN has a better geographic distribution (thank the 3 corporate groups) throughout the country;
- The economics is clear- networks are pro-competitive and put downward pressure on costs – why does the HMI see them as deficient?

Designated Service Provider networks– HMI views

- HMI Provisional report describes the economics of network agreements (DSPs, PPNs, etc) as pro-competitive
- Acknowleges the buyer power of medical schemes
- HMI – sees this as positive but **limited use to date**
- **Main problem as formulated by HMI : geographic distribution of three large hospital groups – cannot exclude one – 'must have' status**

"Provider networks and/or DSPs are a promising tool to introduce competition among hospital groups, but are neutralised by dominance of hospital groups at a local level." (HMI Provisional Report, p. 11)

"As we have seen, each of the larger hospital groups are a must have for the funders in terms of contracting, although individual hospitals may be excluded from DSPs" (HMI Provisional Report, p. 185)

HMI Facilities Seminar Invitation: "*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."* (Facilities seminar invitation, par. 8)

Designated Service Provider networks – HMI perspectives

"The HMI analysis shows that network options have resulted in lower tariffs. Non-network options almost always received a higher average tariff, with the lowest tariffs attributable to networks where the hospital group has a number of hospitals in the network. More notably, analysis shows that smaller schemes which had not outsourced negotiations to administrators were still able to achieve low tariffs through successful implementation of network arrangements with the respective hospital groups. The results also show that there is no significant difference for non-network tariffs between schemes which offer a network option and those that do not. Where there is a difference, it is schemes that have a network option as part of their offering which receive relatively lower tariffs for their non- network options compared with schemes that do not offer a network option. Therefore, 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."(HMI Provisional Report, pp. 221-222)

Are the 3 corporate groups must-haves?
Evidence from scheme lists (available online, accessed early 2019)

Some network options include only geographically isolated Mediclinic facilities, e.g.:

- Fedhealth also includes only 'filler' Mediclinic facilities (differing by option, but only 1-6 MCSA facilities per option network)

Some networks have no Mediclinic facilities, e.g.:

- Spectramed's beneficiaries have access to 167 DSP facilities, including 57 Life and 56 Netcare; no Mediclinic facilities are included
- Compcare (Networx ED) also includes no Mediclinic facilities

Some have relatively few Mediclinic facilities, relative to Life and Netcare, e.g.:

- Compcare (Networx): Mediclinic has 4/34 facilities, i.e. 12%
- Hosmed: Mediclinic has 17/286 facilities, i.e. 6%
- Medshield: Mediclinic has 24/330, i.e. 7%

Some have few Mediclinic, Life and Netcare facilities, and mainly include NHN and independent facilities, e.g.:

- Hosmed: Three have 98/286 facilities, i.e. 34%
- Medshield: Three have 177/330 facilities, i.e. 54%

What is the impact of concentration at the local level on development of DSPs in remote areas?

- HMI Theory of Harm: If there is only 1 hospital in a local market/ region, no network can possible exclude this hospital.
- Evidence: how many of these ‘solus’ hospitals are there in the country? MCSA: Tzaneen, Secunda, Lephalale, Thabazimbi, Upington, Ermelo, and Newcastle.
- Remote areas with no need for more than 1 private hospital;
- DSP discounts are offered nationally, if these hospitals are on the network, same discount will apply.
- DSP negotiations happen at national level (only in highly exceptional case of regional scheme would regional dynamics matter);
- Same principle applies at solus hospitals, if volumes guaranteed, will give discount to scheme;

Designated Service Provider Networks – analysis and findings

Solus hospitals do not provide Mediclinic with market power

- They are too small from the funder's perspective, this can never be practically sufficient for Mediclinic to leverage into another market

Schemes can and do design networks strategically

- This includes schemes' consideration of scheme demographics and beneficiary location; and incorporation of day hospitals, services lines, etc.
- Schemes have the information necessary for the majority of their members, such that they know where their members may require hospitals. This enables them to choose only the hospitals that they require, without limiting this to one hospital group
- Quality is an important factor

Small schemes can and do exercise buyer power in network negotiations with Mediclinic

- Even under an administrator, the scheme can and does influence the network

Mediclinic has to compete strongly in order to be included

Being excluded has a significant and negative impact on Mediclinic

Mediclinic competes to provide the best services in terms of quality, patient satisfaction, and cost. This forms the basis for inclusion in networks

Designated Service Providers - Recommendations

- How will the proposed divestiture/ moratorium increase the buyer power of the schemes?
- If local market concentration is unrelated to DSP negotiations, then why would a structural remedy address this?
- DSP networks are changed by schemes very infrequently, more frequent opportunities to negotiate for network inclusion might make DSPs more efficient.

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Proposed Remedies Justified?

Remedies based on evidence?

- No consistent evidence of highly concentrated markets and trend of declining concentration
- No evidence of *'must have'* status of hospital groups or ineffective bargaining power of medical schemes (DSPs and ARMs)
- No evidence of excessive price increases or excessive profit levels
- No evidence of over-utilisation or supply induced demand, as local concentration study does not support these theories of harm
- Phase 3 of the HMI work is unpublished (e.g. Concentration case studies)

- Hospital markets (beds and admissions) at a national level NOT highly concentrated;
- No reason to impose divestiture based on flawed structural analysis;
- 20% market share – no basis for this?
- Local level – SCP paradigm inverse – less concentrated – more unexplained increases in admissions and expenditure;
- How will divestiture solve this problem?
- There is no basis for divestiture or moratoriums in the structural analysis of hospital markets.

Is there any justification for divestiture or moratoriums?

NO

Unintended consequences

- Impact on quality initiatives
- Divestiture will diminish scale advantages which ensure patient value and quality care. This could take the following forms:
  - Cost efficiencies which are currently used to absorb cost pressures
  - Centralised procurement might be affected, i.e. buyer power vis-à-vis suppliers
  - Ability to use innovative risk adjusted models (such as ARMs)
  - Less Innovation and technological improvements as scale diminishes
- Divestment/ Moratorium remedy will impact negatively on investment

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Are there less invasive and more proportionate interventions?

Mediclinic's Recommendations

These recommendations (next three slides) are generally useful improvements to the competitiveness and efficiency of the market; however they **do not follow from the HMI analyses**

In order to ensure a sustainable and more efficient and competitive private healthcare market, Mediclinic's recommendations are as follows:

1. **Removing barriers to develop integrated delivery models such as HMOs, ACOs and IPAs**
    a. The amendment of the HPCSA ethical rules
    b. This would facilitate contracting with the public sector
    c. Enabling medical scheme regulations
2. **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
    4. The introduction of a risk based solvency approach for medical schemes
3. Effective and accessible training facilities for nurses and doctors with scope for private sector training

Mediclinic's Recommendations

4. Medical schemes to include primary care in their benefit packages enabling GPs to act as custodians of the healthcare of patients
5. The introduction of a low income medical scheme product
6. The industry wide development and introduction of a national grouper
7. **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**
8. Investigating whether the private healthcare sector is subsidising the public healthcare sector's pharmaceutical costs
9. The zero rating of private hospital services from a VAT perspective

Recommendations (continued)

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

1. A tariff negotiation framework which allows the continuation of bilateral negotiations between funders and hospital groups for FFS and ARMs (New Funder Document now refers to multilateral tariff setting (2 April 2019))
2. Improved governance framework for medical schemes
3. A pragmatic, standardised national framework for licensing of facilities - the requirement for approval from funders and the onerous two phased approach are problematic
4. Strategic purchasing of private healthcare services
5. Enabling environment for contracting for value, i.e. to encourage the use of ARMs
6. Health technology assessments or economic value assessments undertaken by an independent body using scientific and transparent methods which take into account value and patient outcomes

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Thank you

Econex has merged with FTI Consulting as of 1 March 2019

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