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Date	30 June 2014

Dear Sirs

MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR: DRAFT STATEMENT OF ISSUES

We represent Mediclinic Southern Africa Proprietary Limited ("**Mediclinic**") in the Market Inquiry into the Private Healthcare Sector ("**Inquiry**").

Mediclinic herein responds to your request for submissions on the Draft Statement of Issues published on 30 May 2014 ("**Statement of Issues**"). References to paragraph numbers in this letter are to the corresponding paragraph numbers in the Statement of Issues, unless otherwise indicated.

This response focuses on the key points that Mediclinic submits the Panel should consider in its formulation of the Statement of Issues. It is not intended to set out Mediclinic's position in respect of the substantive issues raised in the Statement of Issues.

Mediclinic is committed to the long-term sustainability of the private healthcare sector and welcomes the opportunity to work with the Panel as it examines the market. Mediclinic supports the identification of any inefficiencies and, if required, responsible intervention.

1 Executive summary

1.1 The theories of harm in the Statement of Issues are only preliminary hypotheses and, in the absence of evidentiary support, it is not possible for Mediclinic to engage meaningfully therewith at this stage. It is essential that all stakeholders be: (1) provided with the evidence on which the evolving theories of harm are based and (2) be able to make written and oral submissions thereon.

1.2 Below Mediclinic suggests further theories of harm which should be included in the Statement of Issues, and suggests amplifications to some of the existing theories of harm set out in the Statement of Issues.

1.3 The Inquiry aims to understand the factors that increase expenditure, costs and prices in the private healthcare sector in order to make evidence-based recommendations (if required) that serve to promote competition in the interest of more affordable, accessible, innovative and good quality private healthcare. Subject to the submissions herein, this is a sound starting point for the Inquiry.

1.4 However, there are important cost drivers (more fully outlined in clauses 3.7 to 3.15 below) which should be included in the Statement of Issues in order for the Panel to identify and understand the effect of market features and theories of harm on competition (and to be able to determine proportionate and effective remedies should that be necessary). A failure to include a full investigation of the aforesaid cost drivers risks an oversight of important factors that explain competitive outcomes in the private healthcare sector (and an inability to be able to determine proportionate and effective remedies, should that be necessary). In summary, these cost drivers include, -

1.4.1 The features of the public sector which impact directly on costs in the private healthcare market, for example costs relating to private sector nursing and pharmacist salaries and the pharmacy component of private hospital costs (which in Mediclinic's case collectively constitute approximately 62% of its total input costs).

1.4.2 The rules of the Health Professions Council of South Africa ("**HPCSA**"). This arcane regime hampers the ability of hospitals to lower private healthcare costs through *inter alia* employing and integrating medical professionals and ancillary service providers, introducing more innovative product and pricing initiatives, increasing efficiencies and creating a less fragmented system.

1.4.3 The medical schemes regulatory environment has caused major increases in costs for medical schemes, with resultant increases in the contribution rates of members of medical schemes. Regulatory reform is required in order to, amongst others, combat the effects of adverse selection and enhance the competitiveness of medical schemes.

1.4.4 Increased utilisation of healthcare services. A thorough analysis of the factors giving rise to increasing utilisation and the impact thereof on the costs of private healthcare services is required.

1.4.5 The Government's current human resources for healthcare strategy. This limits the ability to increase human resources, negatively impacting on human resource supplies for healthcare, and in turn creating upward pressure on the “price” of these resources.

1.4.6 The impact of stifled innovation. This diminishes the ability of stakeholders to reduce costs in the system through, for example, employing healthcare practitioners and professionals, coordinating care, joint billing, sharing of fees and developing low cost and innovative healthcare delivery models (this is linked to clause 1.4.2 above).

1.4.7 The Council for Medical Schemes ("**CMS**") regularly uses and publishes inaccurate data on basic medical scheme indicators. Distorted measurement norms are likely to continue until such time as the CMS publishes agreed definitions for use by the industry. This also underscores the importance of transparency of information relied upon by the Panel during its investigation.

1.4.8 The prices charged by pharmaceutical companies in respect of consumables, surgicals, implants and prostheses (i.e., collectively, medical devices), all of which are not regulated under the Single Exit Price ("**SEP**") regime (in Mediclinic's experience these

unregulated items account for approximately 66% of its total hospital pharmacy account). The Panel should consider whether there is cross subsidisation to make up for losses in respect of products regulated by SEP.

1.4.9 The effect of public sector pricing and regulation on pharmaceuticals (which has a differential impact for ethicals and medical devices) on private sector pharmaceutical costs.

1.4.10 The effect of variations in quality of service and measuring quality standards on the cost of providing private hospital services.

1.5 The relationship between the framework and the theories of harm in respect of the impending investigation remains unclear and should be clarified.

1.6 A glossary of terms in the Statement of Issues would avoid potential confusion when stakeholders utilise different terminology to describe the same concepts. Mediclinic has made certain suggestions in clause 4.2 below.

1.7 The framework in the Statement of Issues should appropriately contextualise the private healthcare market within the broader health system in which it operates, as the public sector inevitably impacts on choices and incentives within the private sector.

1.8 More detailed comments to the various paragraphs of the Statement of Issues are provided in clauses 4.4 to 4.9 below.

1.9 An Econex paper commissioned by Mediclinic, which sets out techniques for defining relevant markets and analysing competition in the South African private hospital sector is attached as **Annexure 1**.

2 Preliminary formulation of theories of harm

2.1 We note that the theories of harm formulated in the Statement of Issues are preliminary hypotheses intended to serve as a tool for analysis and can be expected to evolve during the course of the Inquiry.

2.2 Since the Panel has not provided any factual or economic evidence in support of these theories of harm, it is not possible for Mediclinic to engage meaningfully with the theories of harm at this stage.

2.3 It is essential that all stakeholders be afforded the opportunity, during the course of the Inquiry, to: (1) consider and assess the strength of the evidence on which the Panel relies in developing particular theories of harm; and (2) make written and oral submissions in respect of theories of harm formulated by the Panel.

2.4 The failure to formulate theories of harm on the basis of sound evidence, gathered during a fair consultative process, will undermine the key objectives of the Inquiry.

2.5 In what follows Mediclinic suggests further theories of harm which should be included among the hypotheses canvassed in the Statement of Issues.

3 The omission of important cost drivers in the Statement of Issues

3.1 The rationale for the Inquiry is founded firmly on increasing expenditure and prices in the private healthcare sector.[1] The starting point for the Inquiry is accordingly the "*evaluation of*

[1] Paragraph 3 of the gazetted Terms of Reference.

the level of prices, expenditure and costs in the sector as well as the reasons for the above-inflation increases in prices in private healthcare".[2]

3.2 We point out that the Terms of Reference require the Panel to "*evaluate the various explanations for cost, price and expenditure increases in the private healthcare sector and …identify the competitive dynamics at play*".[3]

3.3 Mediclinic sets out, in clauses 3.7 to 3.15 below, important cost-drivers which should be fully investigated by the Panel in order to understand the dynamics of the private healthcare market and increases in costs, prices, and expenditure. Mediclinic does not consider these to form closed lists.[4]

3.4 A failure to include a full investigation of the aforesaid cost drivers risks an oversight of important factors that explain competitive outcomes in the private healthcare sector (and an inability to be able to determine proportionate and effective remedies, should that be necessary).

3.5 It is important that the Panel maintains flexibility in respect of the scope of the Inquiry so that the issues prioritised and addressed by the Panel may be expanded, narrowed, or amended in response to emerging evidence.

3.6 Mediclinic agrees with the Panel that the private healthcare sector comprises a number of interrelated markets. Many of its submissions have implications in respect of more than one proposed feature of the market and/or theory of harm.

3.7 **The impact of the public sector on the private sector**

3.7.1 The competitive significance of the public sector is crucial to this Inquiry. It is artificial to consider the competitive dynamics of the market for private healthcare in South Africa in isolation of the public sector.

3.7.2 The Panel correctly notes, under the features section of the Statement of Issues, that it is important to understand how the public and private healthcare sectors interact and what, if any, constraints exist between the two that affect competitive outcomes in the private healthcare sector.[5] Mediclinic supports the Panel's call for submissions on issues pertaining to the public sector that have a bearing on outcomes, competition, costs, prices and expenditure in the private healthcare sector.

3.7.3 Issues pertaining to the co-existence of the public and private healthcare sectors should be incorporated under a separate Theory of Harm. Mediclinic makes suggestions in this regard below (clause 3.7.7).

3.7.4 Whilst Mediclinic understands that the Inquiry is not intended to investigate the public sector, the incorporation of the public sector as a separate Theory of Harm will fall within the scope of the Terms of Reference. <u>This is because many features of the public health system impact directly on the costs of the private healthcare market</u>.[6] For example, the public sector currently has a direct impact on private sector nursing and pharmacist

[2] Paragraph 15 of the Statement of Issues.
[3] Paragraph 3 of the gazetted Terms of Reference.
[4] Indeed, the gazetted Terms of Reference list issues which are omitted from the Statement of Issues and the Panel acknowledges that the Statement of Issues must be read in conjunction with the Terms of Reference and "*is not intended to restrict the scope of the Inquiry*" (paragraph 3 of the Statement of Issues).
[5] Paragraphs 44 to 46 of the Statement of Issues.
[6] "*The Panel…wishes to evaluate the level of prices, expenditure and costs in the sector as well as the reasons for the above-inflation increases in private healthcare….there is a need for a thoroughgoing inquiry into the factors that drive the observed increases in private healthcare expenditure and prices in South Africa*" (paragraph 15 of the Statement of Issues). "*The inquiry will provide a factual basis upon which the Panel can make evidence-based recommendations that serve to promote competition in the interest of a more affordable, accessible, innovative and good quality private healthcare*" (paragraph 16 of the Statement of Issues).

salaries and the pharmacy component of private hospital costs. In Mediclinic's case, these input costs collectively constitute approximately 62% of its total costs.

3.7.5 Human resources for the healthcare sector

3.7.5.1 A key challenge currently faced by the South African healthcare system is the severe shortage of human resources for health, such that there is competition for these resources between the public and private sectors. However, the public sector is not subject to normal market forces, and is not required to make profits or fully fund the salaries of its staff. The public sector remuneration of human resources thus serves as a market distortion which creates an upward pressure on the "price" of healthcare.[7]

3.7.5.2 Recently the public sector has systematically increased the salaries of nurses to attract and retain them in the public sector. This has placed upward pressure on the nursing salaries in the private sector. This initiative, through the Occupation Specific Dispensation (OSD), included the re-grading of nursing staff in the public sector[8] and the consideration of "experience" (in the form of years of experience) in determining salary packages for nurses. Subsequently, preliminary analysis suggests that, for certain categories of nurses, the average Mediclinic nursing salary is between 22% and 29% less than the average nursing salary in the public sector. In order to retain nursing staff and maintain quality of care, the private sector is thus constantly trying to catch up to the current salaries offered by the public sector.

3.7.5.3 This pricing differential takes place in the context of an international shortage of nurses (especially specialised staff such as theatre, ICU, high-care and neo-natal staff) and the high demand for South African nurses in South Africa and worldwide. The local private hospital industry is required to compete both with the public sector and globally in order to attract and retain properly trained nurses.

3.7.5.4 Given that nursing salaries account for approximately 45% of Mediclinic's input costs (excluding pharmaceuticals), the impact of the public sector's upward pressure on the "price" of private healthcare cannot be ignored in an assessment of the cost drivers of private healthcare in the Inquiry.

3.7.6 Procurement of pharmaceuticals

3.7.6.1 The State is a significant purchaser of pharmaceutical products.

3.7.6.2 The pharmacy component accounts for, on average, approximately 30% of the total Mediclinic hospital account. Of this 30%, approximately one-third is the medicines (i.e., ethical / drug) component, which is regulated by the SEP regime[9] and the remaining two-thirds is constituted by medical devices (including surgicals, consumables and implants/prostheses), which are not regulated by SEP (see further at clause 3.14.3 below). The pharmacy portion of a private hospital account is thus a major potential cost driver.

3.7.6.3 It is vital that the Inquiry includes an assessment of how the public sector pricing and regulation of pharmaceuticals, which has a differential impact for medicines and medical devices (including surgicals, consumables and implants / prostheses), affects prices in the private sector.

[7] Private sector hospitals and clinics employ approximately 25,000 nurses, whilst the public sector employs approximately 111,000 nurses. It is estimated that just over 50,000 nurses work in other spheres of the private sector, such as non-governmental organisations (Econex (2010) Health Reform Note 9: *The human resource supply constraint: The case of nurses).*

[8] George L G & Rhodes B (2012) *Is there really a pot of gold at the end of the rainbow? Has the occupational Specific Dispensation, as a mechanism to attract and retain health workers in South Africa levelled the playing field?* BMC Public Health 2012, 12:613.

[9] Save for schedule 0 to 1 drugs which are not subject to SEP. Schedule 2 to 6 drugs are subject to SEP.

3.7.6.4 For example, State tender prices for pharmaceuticals are widely known to be significantly lower than private sector prices. The public sector is also not subject to SEP in respect of medicines. Mediclinic's own analyses of price differentials on select antibiotic medicines indicate that private sector acquisition costs, as per SEP, are on average 254% (i.e., 3.5 times) higher than public sector products of identical brand name and active pharmaceutical ingredient.

3.7.6.5 The Inquiry should consider whether this cross subsidisation of costs of pharmaceuticals from the private sector to the public sector increases the cost of providing private healthcare (i.e., is the private sector making up for the losses incurred by the pharmaceutical companies in the sales to public hospitals?)

3.7.7 Inclusion of the impact of the public sector in the theories of harm

In light of the above, Mediclinic requests that the Panel include the following additional Theory of Harm (the bullet points should not be seen as a closed list):

Theory of harm [•]: Distortions caused by the public sector

- *Assessment of public sector performance on competitiveness and costs in the private sector*
- *Understanding how public sector pricing (salaries) on human resources impacts on prices in the private sector*
- *The impact of State strategies with regard to human resources on the private healthcare sector* [this is linked to clause 3.11 below]
- *Understanding how public sector pricing and regulation on pharmaceuticals (differential impact for ethical items, and surgical items including implants) affect prices in the private sector*

3.8 **HPCSA Rules**

3.8.1 The Panel recognises that the impact of the rules of the HPCSA on competition, with regard to general practitioners and specialists, is a relevant feature to be considered.[10]

3.8.2 The Panel seeks to understand the relationship between practitioners and hospitals insofar as the HPCSA Ethical and Professional Rules ("**HPCSA Rules**") prevent practitioners from being employed by hospitals. Practitioners may however own shares in hospitals. The issue listed for consideration is whether this shareholding is harmful to costs, prices, quality of treatment and competition.[11] Whilst Mediclinic is willing to engage with the Panel during the Inquiry in respect of *inter alia* the rationale and effects of shareholding by practitioners, it is vital that the Panel also separately consider the impact of the general prohibition on employment of medical professionals by hospitals as a cost driver in the private healthcare market.

3.8.3 Mediclinic is aware of a number of other countries with established private hospital sectors, where the private hospitals have the option of employing doctors (for example the United States of America, United Arab Emirates, and Switzerland). Since private hospitals in South Africa generally cannot employ doctors, specialists or other healthcare professionals registered with the HPCSA, hospitals have limited control over the cost contributions of these service providers at the hospitals where they practice. For example, hospitals are not in a position to enforce drug protocols and cost efficient

[10] Paragraph 39 of the Statement of Issues.
[11] Paragraph 41 of the Statement of Issues.

treatment protocols and clinical pathways, promote accountability or offer a viable integrated service delivery. Hospitals are thus hamstrung from engaging in efforts to contain the costs of these service providers.

3.8.4 Hospitals are also not allowed to have an ownership interest in the professional practices of persons registered with the HPCSA, such as pathologists, radiologists, physiotherapists, occupational therapists and dieticians (i.e. this applies to any health professional required to be registered with the HPCSA and does not only apply to doctors).[12] Hospitals do not have control over the ancillary service providers' fees or operations. This reduces the ability to control the overall costs of the services provided at a relevant hospital.

3.8.5 The HPCSA Rules disallow a registered professional from sharing fees or developing global fees with other role players, thus impeding the ability of the hospital and other service providers to collectively develop innovative products and pricing mechanisms that would reduce costs.

3.8.6 In summary, this highly fragmented system means that every health professional works alone and cannot be employed or work in teams, resulting in *inter alia* limited information flow, provider coordination and teamwork; a sometimes frustrating healthcare journey for the patient; medical errors; duplication in testing and many other inefficiencies.[13] The ability of stakeholders to restructure the healthcare system in order to remedy these inefficiencies and provide the highest quality of care at the lowest possible cost is dependent upon amendments to the overly rigid HPCSA Rules.[14]

3.8.7 The Inquiry should consider whether the ability of hospitals to employ doctors and specialists, and a form of vertical integration with ancillary service providers, and/or introducing the flexibility to develop joint product and pricing initiatives, could contribute to lowering private healthcare costs by, amongst other things, creating efficiencies, resulting in a less fragmented / complicated system, and decreasing the number of transacting parties and associated transaction costs.

3.8.8 Alternative mechanisms should be explored through the Inquiry which (1) do not interfere with medical professionals' ability to make clinical decisions, and (2) also allay any ethical concerns (i.e., by ensuring that hospitals are not incentivised to encourage unnecessary treatments).[15]

3.8.9 Inclusion of the impact of the HPCSA Rules in the theories of harm

An investigation of the issues referred to in clause 3.8 can be done under the current -

3.8.9.1 Theory of Harm 4 (barriers to entry and expansion in healthcare facilities, specifically licensing and other regulatory requirements);[16] and

3.8.9.2 Theory of Harm 6 (regulatory framework).

3.9 Medical schemes environment and required reforms

3.9.1 The Panel wishes to understand, as relevant features of the market, (1) the impact of regulatory intervention on competitive outcomes in respect of the financing of healthcare

[12] Rule 8 of the HPCSA Rules.
[13] Jonathan Broomberg, CEO of Discovery Health: Mail and Guardian, 30 May 2014.
[14] Same as above.
[15] With regard to point (2), medical schemes already engage in case management as a measure to prevent over-servicing, whereby if the length of stay expectation for a given procedure is exceeded, further justification has to be provided by the hospital to the scheme in order to obtain authorisation for the longer stay.
[16] In terms of the current theories of harm, the HPCSA Rules only specifically feature as a potential barrier to entry and expansion for healthcare practitioners (paragraph 65 of the Statement of Issues).

services[17] and (2) how risk pooling arrangements, risk equalisation, other risk sharing mechanisms and the rules governing them affect competitive outcomes in the sector.[18]

3.9.2 It is essential that the Inquiry conduct a thorough assessment of the current medical schemes regulatory environment. The regulation of the medical schemes industry in terms of the Medical Schemes Act, 1998 ("**Medical Schemes Act**") has caused major increases in costs for medical schemes, with concomitant increases in the contribution rates of members of medical schemes.

3.9.3 The main purpose of the Medical Schemes Act was to change the medical scheme market from a "pure" health insurance market to a social health insurance market. The former refers to a system where medical schemes were able to manage their risk through risk rating (allowing a scheme to charge a contribution rate which reflects the expected healthcare risk of the covered beneficiary, for example to charge higher contribution rates for older and sicker people and lower rates for young and healthy individuals). The move to a social health insurance system aims to remove such discrimination against people who are older and sicker. However, social health insurance and the solidarity that accompanies it only work if the measures to protect the elderly and sick are balanced by measures to ensure the future stability of the risk pool. The Medical Schemes Act introduced three measures to protect the elderly and sick, namely:

3.9.3.1 Open enrolment (membership) – no one may be declined membership of an open medical scheme, irrespective of their age or state of health;

3.9.3.2 Community rating – medical scheme contribution rates may not differ based on a person's age or state of health; and

3.9.3.3 Prescribed Minimum Benefits ("**PMBs**") – these PMBs have to be covered by all medical schemes and no co-payments are allowed in respect of PMBs.

3.9.4 However, the planned reforms required to ensure the stability and viability of medical scheme risk pools, were not introduced. Social health insurance now exists, but without corresponding measures to protect the viability of the medical schemes. Community rating and open enrolment have not been accompanied by mandatory membership (i.e., a mandatory requirement that all formally employed persons be members of medical schemes) or the implementation of the Risk Equalisation Fund ("**REF**").

3.9.5 Research[19] indicates that adverse selection, whereby the high risk / high cost patients join schemes whilst the low risk / low cost patients choose to self-insure, is taking place. The lack of mandatory membership has resulted in many younger and healthier individuals choosing not to belong to medical schemes. This means that the costs of the medical schemes are not being shared between the younger and healthier members and the older or less healthy members. Consequently, the cost of medical scheme membership has risen at a higher level than it would have, if the medical schemes had a greater number of younger and healthier members. Mediclinic's own data show a consistent increase in the age profiles of medical scheme patients admitted to hospitals, their burden of disease and levels of case mix acuity.

3.9.6 Research using 2007 data estimated that prices of medical scheme contributions in a voluntary environment is around 17% to 23% more expensive than it would be in a

[17] Paragraph 30 of the Statement of Issues.
[18] Paragraph 33 of the Statement of Issues.
[19] McLeod H (2009) Expanding Health Insurance Coverage. IMSA NHI Policy Brief 2; 5 May 2009.

mandatory environment.[20] The effect on costs of the voluntary environment is also evident in the pricing differential between open and closed schemes. Over a ten year period, open schemes had an estimated 30% higher increase in contribution rates than closed schemes.[21] Closed schemes operate in a more mandatory environment and therefore have less exposure to the risk of anti-selection than open schemes. This gives some indication of the magnitude of the effect that anti-selection is having on overall scheme monetary contribution levels.

3.9.7 In the absence of a REF, schemes are incentivised to “cherry pick” the good risks (i.e., the young and healthy) from the market in order to manage their risk of anti-selection. The introduction of the REF would significantly reduce this incentive to "cherry pick" the good risks and would thus lead to greater incentives for schemes to compete on administrative efficiency, the management of healthcare utilisation and preventative care.

3.9.8 Inclusion of the Medical Schemes environment and required reforms in the theories of harm

The impact of the medical schemes environment as a major cost contributor for medical schemes (with resulting increases in the contribution rates of members of medical schemes) should be dealt with under the existing Theory of Harm 6 (regulatory framework) and could also be considered under the current Theory of Harm 4 (barriers to entry and expansion into healthcare financing).

3.10 **Utilisation**

3.10.1 The Statement of Issues make no mention of increased utilisation of healthcare services as a feature of the private healthcare market or a relevant consideration under the proposed theories of harm, despite the Panel (a) indicating that increased utilisation is one of many explanations that have been suggested for observed increases in costs and expenditure in the private healthcare sector[22] and (b) confirming that it seeks to evaluate the reasons for the observed increases in private healthcare expenditure.[23]

3.10.2 The gazetted Terms of Reference provide that one of the factors that explain increasing private healthcare expenditure is utilisation and specifically require that "*the veracity of this data and the underlying drivers of increased expenditure must be evaluated during the inquiry*".[24] It is thus clear that the Panel is required by the Terms of Reference to include utilisation within the scope of its investigation.

3.10.3 Medical scheme healthcare expenditure is driven by both (1) the rate of utilisation of healthcare and (2) the unit price of healthcare. Currently, the Statement of Issues appears to only consider the price aspect of the equation. The Panel cannot conduct a feasible investigation into the costs of private healthcare without a full investigation into utilisation of healthcare services.

3.10.4 Analysis by Econex estimates that approximately 60% of the real increase in medical scheme expenditure on private hospitals is due to factors other than price increases, including increased utilisation and increased acuity of care.[25] Increased utilisation by medical scheme beneficiaries is clearly driving up medical scheme contributions and reducing the affordability of medical scheme cover.

[20] McLeod H, Grobler P (2009). The role of risk equalisation in moving from voluntary private health insurance to mandatory coverage: the experience in South Africa. In: Chernichovsky D, Hanson K, eds. Advances in Health Economics and Health Services research. Vol 19: Health Care Financing in Low-and Middle-Income Countries: Emerald Group.
[21] Childs B (2012). The impact of mandatory membership on healthcare affordability, BHF conference 2012.
[22] Paragraph 17 of the Statement of Issues.
[23] Paragraph 15 of the Statement of Issues.
[24] Page 83 of the gazetted Terms of Reference (our own underlining).
[25] Econex *Occasional Note August 2012 – Medical Scheme Expenditure on Private Hospitals.*

3.10.5 Discovery Health has recently submitted that, in terms of its health population, chronic disease prevalence has increased by 25% in the past four years, with each chronic member costing four times more than a non-chronic member.[26] The growing prevalence of chronic diseases as a contributor to increasing utilisation has also frequently been reported on by the CMS.[27]

3.10.6 Various factors may be giving rise to an increase in utilisation of private healthcare services by medical scheme beneficiaries, such as the impact of new medicines, medical innovation, use of more intense modalities of care, deterioration in medical scheme membership profiles, ageing populations, increases in the burden of disease, increased expectation of the private health system and failure of the public healthcare system.

3.10.7 The Inquiry should go beyond a narrow price-based focus and include a thorough analysis of the factors giving rise to increasing utilisation and the impact thereof on the costs of private healthcare services.

3.10.8 Inclusion of increased utilisation in the theories of harm

An assessment of hospital utilisation on total expenditure by medical schemes (and all other primary drivers of hospital costs) should be considered in the context of Theory of Harm 2 (market power and distortions in relation to healthcare facilities).

3.11 Human resource strategies

3.11.1 There is wide acknowledgement that there is a severe shortage of human resources in healthcare, including nurses and doctors. The Statement of Issues mentions the scarcity of skills only under Theory of Harm 3, which deals with market power and distortions in relation to healthcare practitioners.[28]

3.11.2 However, the Statement of Issues does not specifically address the Government's human resources for healthcare strategy. The current strategy limits the ability to increase human resources, which negatively impacts on human resource supplies for healthcare, and therefore creates upward pressure on the "price" of these resources.

3.11.3 Examples of the difficulties that Mediclinic has faced in the potential training of nurses and doctors include:

3.11.3.1 Delays in the accreditation of the new nurse training curriculum/qualification by the South African Nursing Council ("**SANC**") have limited the ability of private training facilities to train certain categories of nurses. The Government has closed its nursing colleges. Although the Government has indicated an intention to re-open them, this has not occurred.

3.11.3.2 The private sector (including Mediclinic) has established nursing training schools, where nurses of all levels study and post-basic training is also offered. The SANC however places an unreasonable cap on the number of first year nursing students that a facility may accept, thereby also indirectly limiting the number of nurses that qualify and take up the profession.

3.11.3.3 The output of medical schools (MBChB graduates) has remained stagnant in the past decade, despite Government's plans to expand the capacity of medical schools to train more doctors.

[26] Jonathan Broomberg, CEO of Discovery Health: Mail and Guardian, 30 May 2014.
[27] For example, the CMS' 2012 analysis showed that the most prevalent PMB chronic condition in medical schemes was hypertension at 118.8 cases per 1,000 beneficiaries (114.6 in 2011), followed by hyperlipidaemia at 54.2 (52.2 in 2011), diabetes mellitus type 2 at 34.9 (32.3 in 2011), and asthma at 28.4 (29.3 in 2011) (CMS Report 2012-2013 at page 238).
[28] Paragraph 61 of the Statement of Issues.

3.11.3.4 In addition the private sector may not play any role in the training of medical practitioners. This is unfortunate as Mediclinic generally finds that the medical practitioners practising at its hospitals have a wealth of clinical and practical experience which they are willing to share. This could form part of the formal training of a university medical qualification.

3.11.4 Inclusion of human resource strategies in the theories of harm

The impact of the Government's human resource strategies on private healthcare costs should be considered under the existing Theory of Harm 6 (regulatory framework). The issue can also be investigated under Theory of Harm 4, as a potential barrier to entry and expansion in healthcare facilities (i.e., in respect of private healthcare training) and as a potential barrier to entry and expansion for healthcare practitioners.

3.12 **Innovation**

3.12.1 Innovation is indirectly recognised by the Panel insofar as it is considered a substantive criterion to assist the Panel in prioritising its work during the Inquiry.[29] Innovation is also indirectly considered as a potential effect, which the Panel seeks to understand in more detail during the Inquiry, arising in relation to each of the Theories of Harm.[30]

3.12.2 Inclusion of innovation as a relevant feature of the private healthcare market

Mediclinic emphasises the importance of innovation in any discussion of the features of the private healthcare market. The present cost of private healthcare reflects the giant steps that have been taken by hospitals over the years both in the way patients are treated (for example, technological improvements that enhance the accuracy of treatment) and the scope and quality of care that private hospitals are now able to deliver (for example, expanding care into high-acuity tertiary cases, and providing a high standard of clinical infrastructure and staffing). These forces mean that there is also a requirement that hospitals maximise efficiency and continuously innovate in order to remain competitive, and ensure that they have adequate funding to continue to invest. Innovation thus requires careful consideration in this Inquiry and the Panel should not lose sight of this feature during the course of its investigation.

3.12.3 However, other forms of innovation have been stifled through the impact of the regulatory framework, which limits the ability of stakeholders to reduce the costs in the system through, for instance, employing healthcare practitioners and professionals, coordinating care, joint billing, sharing of fees and developing low cost models. These issues must be considered in the Inquiry.

3.12.4 Health maintenance organisations ("**HMO's**") are an example of an innovative healthcare delivery model which aims to provide holistic, proactive, preventative care that seeks to keep patients healthy and out of hospitals and thereby reduce costs. The market may not implement HMO-type innovations unless there is a more flexible regulatory environment which, for example, permits joint product and pricing efforts by healthcare role players, vertical integration and the employment of doctors. This is because sharing of information, the achievement of efficiencies and the ability to control and contain costs are essential to the financial viability of HMO-type healthcare models.

3.12.5 Inclusion of the lack of flexibility of current regulatory regime in the theories of harm

The lack of flexibility of the current regulatory regime should be considered under the current Theory of Harm 6 (Regulatory Framework).

[29] Paragraph 19 of the Statement of Issues.
[30] Paragraph 55 of the Statement of Issues.

3.13 **CMS**

3.13.1 The CMS is a statutory body that is tasked with regulation of medical schemes. However, it has been of concern that the CMS regularly uses/publishes inaccurate data on basic medical scheme indicators, such as healthcare utilisation measurements and demographic profile indicators of beneficiaries. Mediclinic has on numerous occasions engaged the CMS on these issues. In a recent CMS circular, the CMS refers to a number of discrepancies in the information currently being furnished by medical schemes in their statutory returns.[31] These discrepancies, which distort measurement norms, are likely to continue until such time as the CMS publishes agreed definitions for use by the industry.[32]

3.13.2 The use by the CMS of incorrect information in providing regulatory oversight may affect the ability of the CMS to effectively carry out its mandate, and could be a potential risk for regulations developed by the CMS.

3.13.3 Recently, the CMS established an Industry Technical Advisory Panel ("**ITAP**"), which has since generated, but not published, more credible information on various indicators of the medical scheme industry. It is however not clear whether the information generated by ITAP is being appropriately incorporated into regulatory oversight by the CMS.

3.13.4 Inclusion of the role of the CMS as an information resource in the theories of harm

An investigation of the role of the CMS as an information resource can be done under the current Theory of Harm 5 (imperfect information).

3.13.5 The use by the Panel of incorrect information from the CMS could affect the outcomes of the Inquiry. This underscores the importance of transparency in respect of the information relied upon by the Panel during its investigation, as more fully set out in Mediclinic's response to the Draft Guidelines for Participation in the Inquiry ("**Draft Guidelines**").

3.14 **Pharmaceuticals: medicines and medical devices**

3.14.1 The gazetted Terms of Reference specifically refer to healthcare goods, such as medical devices and pharmaceutical products, as being a relevant market included in the private healthcare sector.[33] Similarly, the Statement of Issues provides that the Panel wishes to understand the impact of consumables on costs and competition in private healthcare.[34] Mediclinic agrees with the Panel's identification of this key issue.

3.14.2 However, based on the Panel's current formulation of the theories of harm, pharmaceutical companies are notably absent. It is thus unclear how the Panel's goal of understanding the impact of pharmaceuticals on costs and competition in private healthcare can be met in practice. Mediclinic has made suggestions in this regard (please see clause 3.14.7 below).

3.14.3 The Statement of Issues provides that "*the consumables market includes pharmaceutical products and other medical consumables. Pharmaceuticals form a considerable part of*

[31] Circular 30 of 2014: *General Notification: General Concerns Noted During the Analysis of the 2013 Annual Financial Statements and Statutory Returns* dated 19 June 2014.

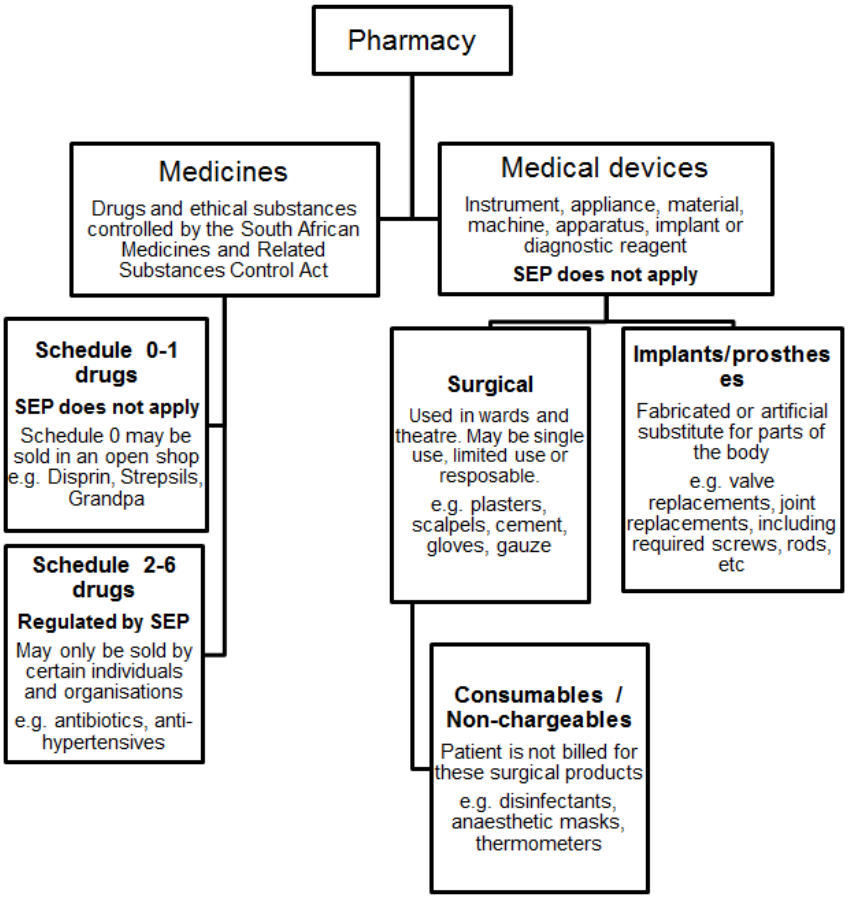
[32] For example, according to CMS data, the movements in private hospital admission rates for the period 2008 - 2010 were very volatile. Mediclinic data for the 24 largest medical schemes in respect of the same period showed stable admission rates (i.e., with the CMS showing changes in the admission rates of the same schemes). Upon further investigation Mediclinic discovered that only in-hospital admissions were treated as "admissions" by the CMS in 2008, whilst the category was expanded to include same day admissions in 2009 and 2010. This use of different definitions for admissions resulted in higher admissions being reported in the latter years.

[33] See paragraph 2.1.1 of the gazetted Terms of Reference.

[34] Paragraph 43 of the Statement of Issues.

consumables and operate within a highly regulated market through the Single Exit Pricing (SEP) regime…"[35] <u>These statements are incorrect. The prices of consumables, as well as all surgicals, implants and prostheses (i.e., collectively, medical devices), are not regulated under the SEP regime</u>.

3.14.4 In an effort to assist the Panel in utilising standardised terminology for pharmaceuticals during the Inquiry, the following explanation is provided, -



3.14.5 The unregulated items account for a major portion of the hospital pharmacy account (approximately 66% in Mediclinic's experience). The total hospital pharmacy account in turn makes up approximately 30% of the total hospital account. It is therefore clear that market dynamics for pharmaceutical medical devices, such as surgicals (including consumables) and implants/prostheses must be assessed in the Inquiry.

3.14.6 The Inquiry should consider *inter alia* whether pharmaceutical companies are engaging in a form of cross subsidisation on the medical devices component of their products due to perceived "losses" made on the regulated, SEP portion (please see further at clauses 3.14.3 and 3.7.6 above).

3.14.7 <u>Inclusion of pharmaceutical companies in the theories of harm</u>

In light of the above, Mediclinic proposes that the following additional Theory of Harm be included (again emphasising that the list should not be seen as a closed one):

[35] Same as above.

Theory of harm [•]: Market power and distortions in pharmaceutical companies

- *An analysis of pricing and regulation on pharmaceuticals (differential impact for medicines and medical devices including surgicals, consumables and implants / prostheses)*

- *Understanding how public sector pricing and regulation on pharmaceuticals (differential impact for medicines, and medical devices including surgicals, consumables and implants/prostheses) affect prices in the private sector* [this is linked to clause 3.7 above]

3.15 **Quality of Care**

3.15.1 The Panel recognises that quality outcomes are among the effects of the various theories of harm which must be understood.[36]

3.15.2 Whilst healthcare funders' ability to compare cost and quality information when contracting is dealt with under Theory of Harm 5 (imperfect information),[37] it is notable that there is no discussion in the Statement of Issues on the impact of quality on competitive outcomes for hospitals. Prices and costs are not the sole indicators of competition in a market and other factors such as quality, innovation and product / service range provide evidence about the functioning of the competitive process.[38] The absence of any quality discussion, a key differentiator in respect of hospitals, is a material omission from the analysis, especially in an industry which is far from commoditised.

3.15.3 Mediclinic is dedicated to providing the best possible quality of care and has invested significant resources over time in improving the quality of care in its facilities across all treatments and across a range of quality indicators. Mediclinic monitors patient satisfaction levels (measuring indicators such as the admission process, catering service, nursing care, discharge, hygiene, amongst others), through independent agencies, the results of which have been very positive. Mediclinic also participates in international quality certification programmes.

3.15.4 All Mediclinic's efforts in monitoring the quality of its services have been at its own cost. Accordingly, any assessment of prices of private hospitals should include a concomitant assessment of the quality of the services being offered.

3.15.5 Currently there are no standardised measurements for quality outcomes in South Africa, making effective quality comparisons very difficult. Whilst the Office of Health Standards Compliance ("**OHSC**") has been created, it is still in its infancy and the much needed standardised quality measurements have not yet been created.

3.15.6 It is unlikely that the quality measurements proposed by the OHSC are sufficiently comprehensive for patients to make informed choices when assessing the quality of care at the provider level for a particular diagnosis or treating doctor.

[36] Paragraphs 19 and 55 of the Statement of Issues.
[37] Paragraph 67 of the Statement of Issues.
[38] United Kingdom Competition Commission, *Guidelines for market investigations: Their role, procedures, assessment and remedies* (April 2013), paragraph 127.
[38] Again, given the current regulatory framework, the lack of integration means that hospitals do not have visibility over the entire practices of healthcare practitioners and professionals working at their hospitals and, as such, the ability of the hospitals to report on the quality of clinical outcomes (such as information in respect of patient episodes or procedures carried out by individual practitioners) is inherently limited.

3.15.7 Including quality of care in the theories of harm

3.15.7.1 Quality of care must be included as a pivotal factor contributing to variations in the cost of care from a hospital perspective. This can be done under Theory of Harm 2 (market power and distortions in relation to healthcare facilities).

3.15.7.2 The cost implications of regulatory intervention in respect of the monitoring of quality standards of hospitals should also be considered. This can be done in terms of Theory of Harm 6 (regulatory framework).

4 General comments

4.1 Mismatch between the framework and the theories of harm

4.1.1 The Panel sets out a fairly detailed framework for approaching the investigation which it describes as the "*issues the Panel envisages being most relevant to answering the questions arising from the Terms of Reference*". The framework also represents "*topics for investigation*"[39] and "*focus areas*".[40] The Panel invites comments on the framework and specifically provides that, if parties are aware of additional issues that the Panel should consider, they should explain how these are relevant to the investigation.[41]

4.1.2 The Panel then identifies several "theories of harm" each of which refers to "*a hypothesis about how harm to competition might arise in a market to the detriment of consumers and to the detriment of efficient and innovative outcomes in the market*",[42] in a much less detailed form than the framework. The suggested intention is for the theories of harm to help in the identification of the most important issues to be addressed and enable more efficient concentration on relevant information.[43] The Panel has requested comments on the proposed theories of harm.

4.1.3 The relationship between the framework and the theories of harm in respect of the impending investigation remains unclear. For example, there is inconsistency in the Panel's approach to the features of the market on the one hand and the proposed theories of harm on the other hand.

4.1.4 Further, if the framework provides for topics of investigation, it should be made clear that the features described in the framework (and other relevant features which are identified in the course of the Inquiry) will be assessed in terms of the theories of harm.

4.2 Terminology

A glossary of terms in the Statement of Issues would avoid potential confusion when stakeholders utilise different terminology to describe the same concepts. The following suggestions are made, -

4.2.1 "**Costs**" - Actual expenses incurred by the provider of a healthcare product or service in order *to provide* that product or service. The total cost of a unit of healthcare is therefore an aggregate of all the input costs required to produce a unit of healthcare;

4.2.2 "**Expenditure**" - The amounts spent by individuals, groups, nations, and/or private or public organisations for total health care and/or its various components. Expenditure is usually a function of the price paid for that product/service and the quantity purchased;

[39] Paragraph 6 of the Statement of Issues.
[40] Paragraph 20 of the Statement of Issues.
[41] Same as above.
[42] Paragraph 4 of the Statement of Issues.
[43] As explained in paragraph 11 of the Statement of Issues, the theories of harm are "*tools that will guide the inquiry*" and "*questions that the inquiry will explore*".

4.2.3 "**Price/tariff**" - The nominal amount of money paid per unit for a good or service; and

4.2.4 "**Utilisation**" – The rate of use of services and supplies. Utilisation is commonly examined in terms of patterns or rates of use of a single service or type of service, such as hospital admissions, medical practitioner visits or prescription drugs. Use is expressed in rates per unit of population at risk for a given period, such as the number of admissions to hospital per 1,000 persons per year, or the number of visits to a medical practitioner per person per year.

4.3 Background: The contextualisation of the broader health system

4.3.1 The private healthcare market should be appropriately contextualised within the broader health system in which it operates, as the latter inevitably impacts on choices and incentives within the former. Private hospitals are only one component part of the private healthcare "ecosystem". The private healthcare sector itself does not exist in a vacuum and is inevitably affected by conditions and events in the public sector. This contextualisation is currently missing from the Framework.

4.3.2 The South African health system is a dual healthcare system. There is a publicly funded (through general tax revenue) and publicly provided healthcare, which largely operates parallel to a privately funded (mostly through individuals purchasing medical cover from their personal income)[44] and privately provided health sub-system. Approximately 17% of the population are members of medical schemes. Membership to medical schemes is voluntary, although contribution to medical schemes may be a condition of service for some employees. Membership to medical schemes requires member contributions on a monthly basis, depending on the particular scheme and/or scheme option. The public sector provides comprehensive cover for an undefined range of conditions, and is heavily subsidised. It is free at the point of service for children below the age of 6, pregnant women, nursing mothers, the elderly, disabled, primary healthcare services and certain categories of the chronically ill. For other services provided in the public sector, patients are subjected to a fee calculated on a sliding scale in relation to patients' income levels in accordance with the Uniform Patient Fee Schedule.

4.3.3 Previous research has shown that there are significant disparities in the quality of care provided by the public and private sectors. The public sector is characterised as 'performing poorly' in terms of both quality and responsiveness to health care needs.[45] On the other hand, the private sector performs at a much higher level of quality. Individuals have a choice between using private healthcare services (either by joining medical schemes or on an out-of-pocket basis). A significant proportion of non-medical scheme members utilise private healthcare services (mainly GP services) on an out-of-pocket basis. It is estimated that in total, 28% to 38% of the South African population uses private sector services.[46]

4.3.4 It is safe to assume that the failure of the public hospital system gives rise to an increase in utilisation of private healthcare services, which in turn has a direct impact on cost.

4.4 Ad paragraph 13: Constitutional commitment

4.4.1 The Panel states, as the rationale for the Inquiry, that private healthcare provision takes place within the context of a constitutional commitment to the provision of universal healthcare services to all South Africans.

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[44] Note that in certain cases, employers pay a portion of the scheme member's contribution (which is tax exempt). Also, medical scheme members may receive a tax credit on their medical scheme contributions.

[45] *Development Bank of South Africa. A roadmap for the reform of the South African health system*. Johannesburg: Development Bank of South Africa, 2008 Nov 8.

[46] Econex: *The South African Private Healthcare Sector: Role and Contribution to the Economy* November 2013 at page 18.

4.4.2 Whilst this is correct, and whilst Mediclinic supports the goal of universal healthcare services, it is important to recognise that the obligation to promote and fulfil every person's constitutional right to have access to health care services is an obligation which lies with the State.

4.4.3 The goal of affordable and accessible *private* healthcare cannot be unqualified. Private healthcare in South Africa is not intended to be available to the entire population; it exists in parallel to a public system, which must be accessible to any person who cannot afford private healthcare.

4.5 **Ad paragraphs 27 to 34: Financing of healthcare services**

4.5.1 It is noted that the issues highlighted in respect of private hospitals include issues which have significant enforcement consequences under the Competition Act, such as concentration and market power of hospitals, the impact of market power on bargaining between hospitals and medical schemes / administrators ("**funders**"), the level and structure of hospital prices and the determination of hospital profits. However, these issues are not canvassed in relation to the features section pertaining to the entities financing healthcare services.

4.5.2 This may result in a "one sided" presentation of the issues and a misleading and incomplete picture of the market. Mediclinic believes that this approach has significant shortcomings as a framework to assess the relative strengths of hospitals and funders. The issues should include the ways in which funders might exercise buyer power over hospitals.

4.6 **Ad paragraphs 35 to 37 and 41: Providers of healthcare services (hospitals)**

4.6.1 Mediclinic notes the Panel's description of the features of the market for private hospitals in paragraphs 35 to 37 and paragraph 41 of the Statement of Issues and looks forward to engaging with the Panel on these issues in its substantive submissions during the course of the Inquiry.

4.6.2 The Panel has not provided any factual or economic evidence in support of the claims made in respect of hospitals in the Statement of Issues, and it is thus not possible for Mediclinic to substantively respond to the various features and theories of harm at this stage. It is however essential that all stakeholders be provided with the opportunity to consider and assess the strength of the evidence on which the Panel is proposing to rely during the course of the Inquiry, as more fully explained by Mediclinic in its comments to the Draft Guidelines (please also see clause 2 above).

4.6.3 Mediclinic will evidence to the Panel during the course of the Inquiry that any competitively undesirable features of the market do not result from the alleged market power of Mediclinic or the abuse of alleged market power by Mediclinic.

4.7 **Ad paragraph 43: Consumables**

As more fully explained in clause 3.14.3 above, it is incorrect to state that consumables are regulated by the SEP. The prices of all medical devices (i.e. surgicals, including consumables and implants / prostheses) are not regulated under the SEP regime.

4.8 **Ad paragraphs 47 to 50: Techniques for defining markets and analysing competition**

Pursuant to the Panel's invitation to stakeholders to make submissions on the appropriate techniques for defining markets and analysing competition,[47] we attach as **Annexure 1**, an

[47] Paragraph 51 of the Statement of Issues.

Econex paper commissioned by Mediclinic which sets out techniques for defining relevant markets and analysing competition in the South African private hospital sector.

4.9 **Ad paragraphs 59 and 60: Market power and distortions in healthcare facilities**

The contents of clause 4.6 above apply.

Mediclinic hopes that these comments are helpful and looks forward to engaging with the Panel on a substantive basis as the Inquiry progresses. We will gladly amplify any of our aforementioned comments should that be required.

Yours sincerely

ANDRÉ DE LANGE / SUSAN MEYER
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