

Competition Policy in SA – focus on healthcare.

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Actuarial Society - Johannesburg

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| Structure

- Competition issues and main focus;
- Competition Issues in Healthcare;
- Theory of harm in healthcare sector;
- CC theories of harm;
- Hospital mergers and evidence from the data;
- Role of healthcare enquiry.

| Competition issues

- Competition Act (nr. 89 of 1998);
- 16 years of competition enforcement;
- Mergers – forward looking;
- Restrictive practices – horizontal (section 4), vertical (section 5);
- Abuse of dominance – SAA/ BATSA/ Sasol.
- Market enquiries – Banking/ Grocery/ Healthcare
- Findings?

| Main focus

- **Food and Agro processing:**
 - Walmart – Public Interest/ CAC? R200 million;
 - Grocery enquiry – exclusive leases;
 - Oceana;
 - Senwes;
 - Pioneer.
- **Intermediate Industrial Products:**
 - Flat steel – Mittal (excessive pricing);
 - Glass cartel;
 - Glencore/ Xstrata (merger);
 - Omnia/ Sasol - fertiliser
 - Sasol - polypropylene

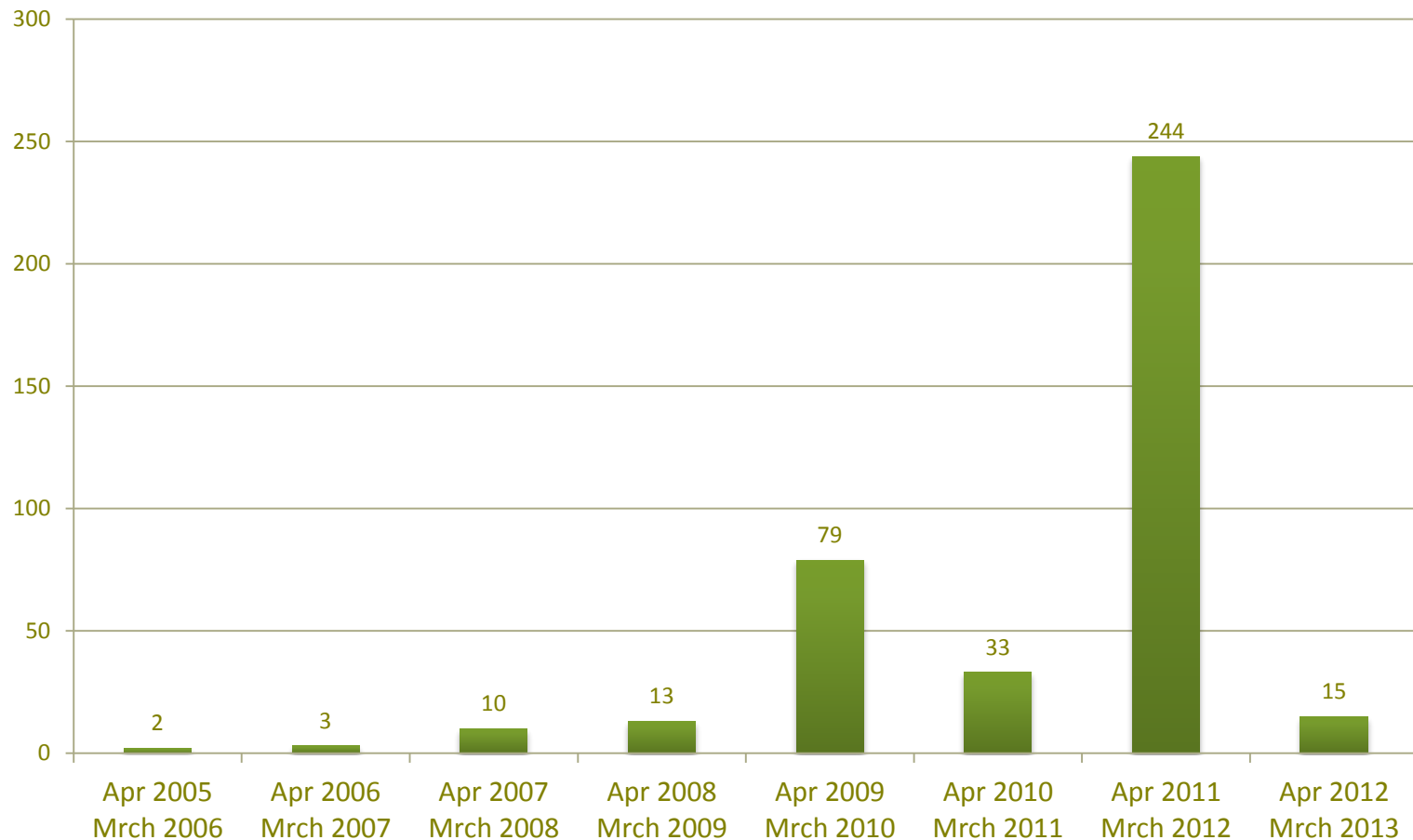
| Main focus

- **Infrastructure and Construction:**
 - Construction firms (SANRAL, Soccer stadiums);
- **Telecoms**
- **Healthcare:**
 - Mergers;
 - Exemptions (e.g. NHN);
 - Healthcare enquiry.

Table 1:
Merger
review by
type over a
three-year
period

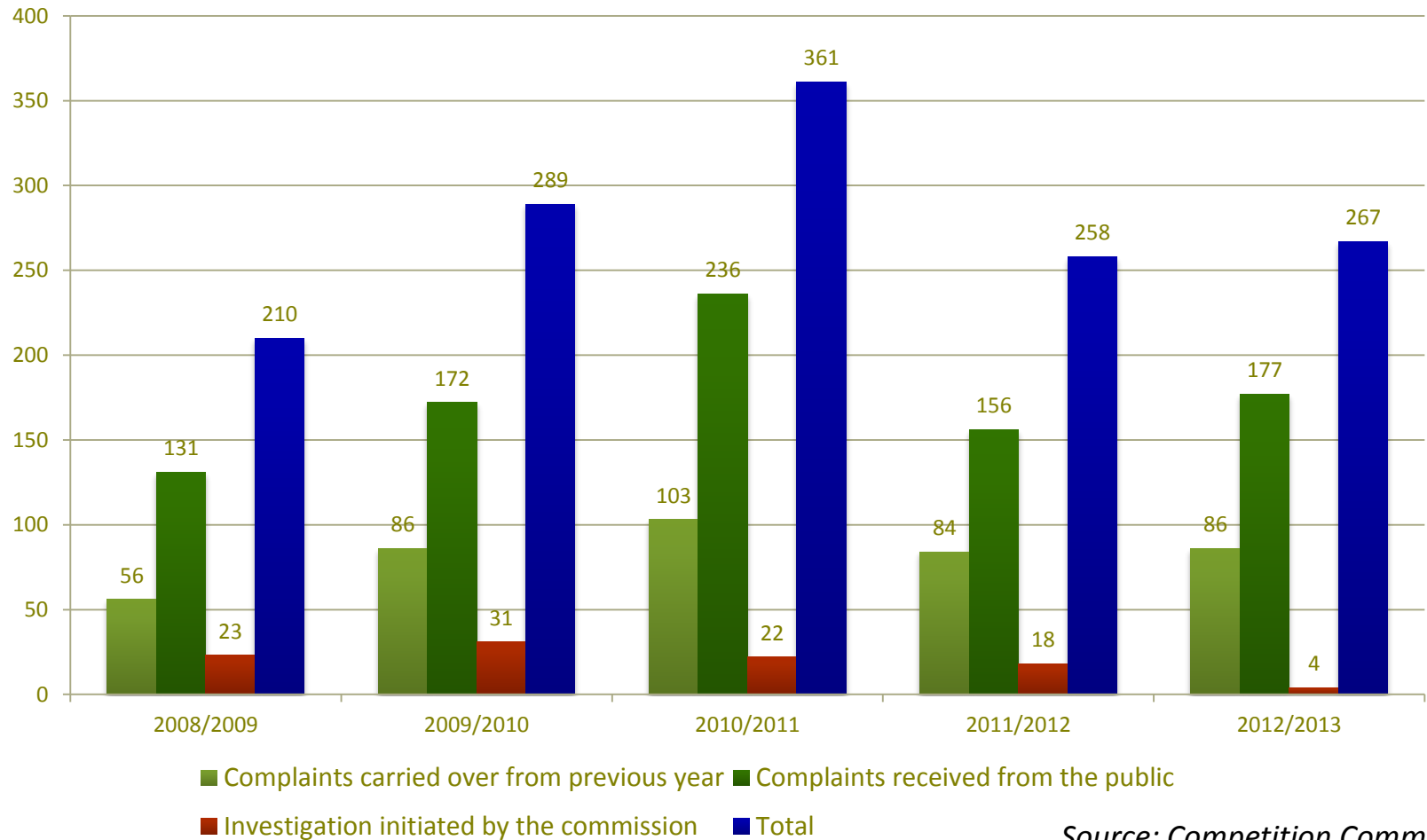
	2010–2011	2011–2012	2012–2013
Notified	229	291	324
Large	60	88	68
Intermediate	150	186	223
Small	19	17	33
Finalised	219	282	327
Large	55	85	70
Intermediate	145	182	227
Small	19	15	30
Unconditionally approved	200	234	278
Large	49	72	55
Intermediate	135	155	200
Small	16	7	23
Conditionally approved	13	33	37
Large	6	10	12
Intermediate	4	19	22
Small	3	4	3
Prohibited	2	8	0
Large	0	1	0
Intermediate	2	4	0
Small	0	3	0

Figure 1: Total number of CLP applications received per year



Source: Competition Commission

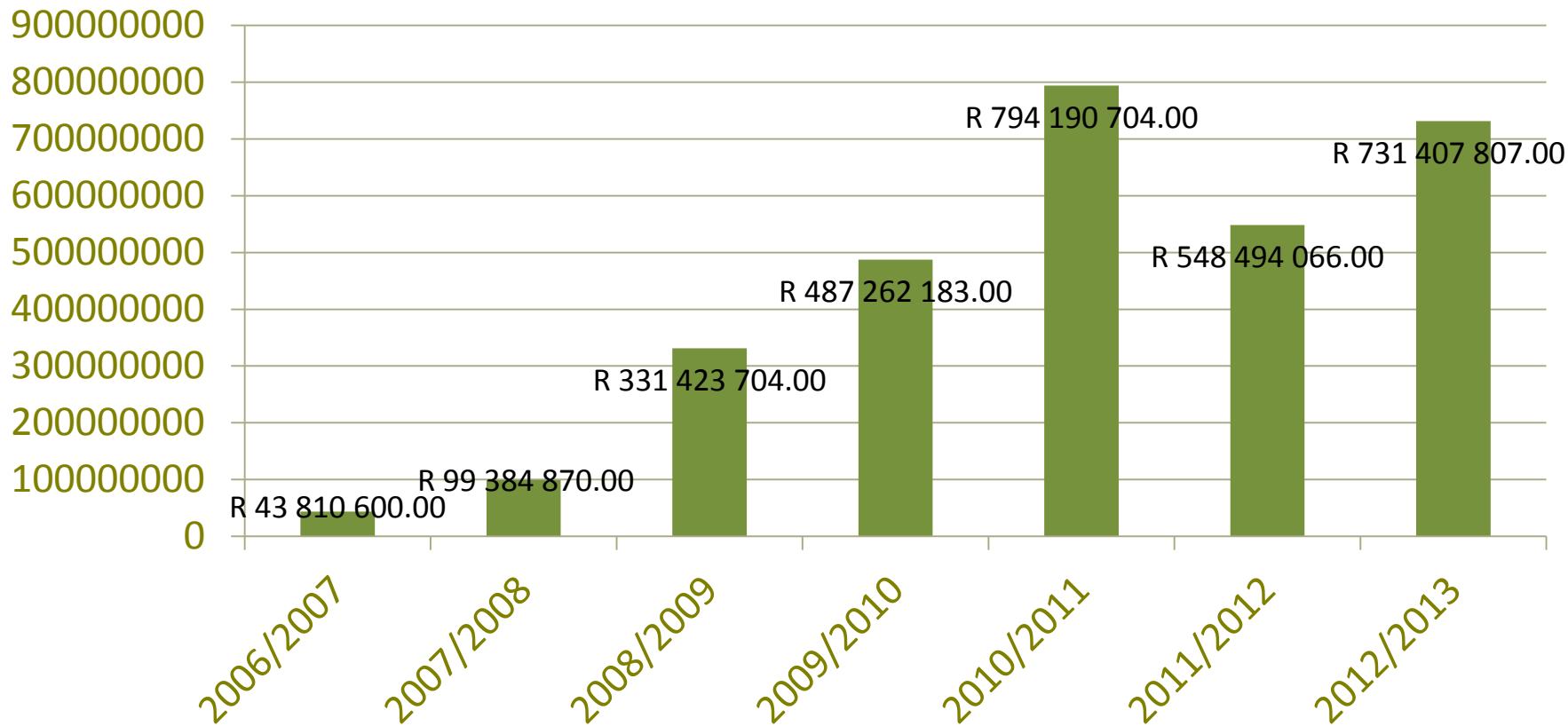
Figure 2: Enforcement cases under consideration, by year



Source: Competition Commission

Total administrative penalties

Value of penalties (Rand)



Competition policy and healthcare

- **Information asymmetries and distorted incentives;**
- **Lack of price sensitivity, third party payment;**
- **Principal-agent problems;**
- **Healthcare has many special features:**
 - Basic level of healthcare is regarded as a human right;
 - Private provision has a mixture of challenging market features, e.g.
 - Third party payer for insured services
 - Information asymmetry between consumer and provider
 - Adverse selection in insurance
- **Public vs private provision;**
 - Range of regulations around private provision in place to supposedly address some of the market features, e.g.
 - PMBs, open enrolment and community rating
 - Outlawing the employment of doctors by private hospitals, generic substitution
 - Medical scheme contracting initiatives to overcome market failures e.g. networks and managed care.

Healthcare issues

- **Challenge facing all countries is the escalating cost of healthcare**
 - Increased burden on taxpayer-funded public provision and shortage of healthcare resources
 - Ability of private provision to become more affordable to a greater proportion of the population and relieve the public sector
- **OECD (2012: Policy Roundtable: Competition in Hospital Services) : “Concerns about increasing healthcare expenditures are a major motivation for introducing competition in hospital services. While competition on quality can lead to better outcomes, competition on prices has uncertain results. An active governmental role is key in ensuring quality provision and containing costs”.**

Role of competition law

- **Many see Competition Law as a potentially important tool to address cost concerns in the healthcare market**
 - It has jurisdiction over the entire economy including healthcare
 - It has significant powers to compel information and fine
- **But a limitation is that the primary focus of Competition Law is the maintenance of pre-existing competition levels (merger control) or investigating very specific types of behaviour (abuse of dominance, cartels) the impinge on competition**
 - Not necessarily measures aimed at enhancement of competition
- **Competition law is specialist in competition, but generalist across sectors (not sector specialist), and the quality of some previous decisions have been hotly debated (rightly or wrongly)**
 - E.g. Outlawing collective negotiations and hospital merger control;
 - Role of other regulators in the sector?

Centralised negotiations – the CC decision

- **Competition Tribunal (2004) - The CC and HASA. Case No: 24/CR/Apr04**
- **Example of Competition Commission interference:**
 - HASA decision in 2004 (as well as fine for 4(1)(b)(i) = R4.5 million);
 - Centralised bargaining was stopped, although it was a ‘recommended tariff’;
 - HASA had exemption for tariff negotiations up to 2000;
 - BHF tariffs were published in Government Gazette;
 - Tariff negotiations and tariffs had real advantages (new hospitals, and speedy settlement of claims)
- **But regulation has its own issues and may not always achieve the best outcome, e.g.**
 - Information asymmetries and what is the appropriate price
 - Potential incentive to impose unrealistically low prices to contain costs but hindering investment and quality/levels of provision
 - Potential to distort incentives to increase efficiency or innovate

CC: The enquiry

- What anti-competitive behaviour or market structure drives high costs?;
- This is not a complaint/ merger or abuse case – investigative powers will be used;
- Justice Ngcobo: ‘Market enquiries provide a framework for identifying, analyzing and, where appropriate, remedying sector-wide competition problems...’
- What we need to emphasize is the point that other jurisdictions have emphasized; a market enquiry is fundamentally investigative and inquisitorial in nature; it is not accusatorial. No one is accused of anticompetitive conduct; the focus is on how the market as a whole functions”.
- Possible outcomes: Recommendations, new or amended policy, regulation or deregulation, and an investigation of an alleged prohibited practice (CC may initiate a complaint).

UK Enquiry (2012-2014)

- The OFT received over 100 consultation responses, from healthcare providers, private medical insurers (PMIs), consultants, medical professionals, professional bodies and individual consumers.
- Having taken into consideration these submissions, the study will focus on the following issues:
- The nature of competition in private healthcare provision - in particular how private healthcare providers compete on the price and quality of treatment. This will include the NHS's role as a provider of privately-funded healthcare, for example through its private patient units.
- Concentration of provision - whether concentration at the national, regional and/or local levels might be limiting the extent of competition in the market.
- Barriers to entry - whether the relationships between private healthcare providers, PMIs, consultants and GPs may restrict entry and/or expansion, and whether there are other restrictions on the ability of providers to enter or expand into the market.
- The role of consultants - whether restrictions placed by healthcare and PMI providers on consultants and other medical professionals limit choice and quality of care for patients, and the role of consultants more generally in determining how patients are treated, where they are treated and by whom.
- Constraints on consumers - how consumers access and assess information about private healthcare providers, and how they exercise choice.

| UK CC Theories of Harm

1. Market power of hospital operators in certain local areas;
2. Market power of individual consultants and/or consultant groups in certain local areas;
3. Market power of hospital operators during national negotiations with insurers;
4. Buyer power of insurers in respect of individual consultants [GPs and specialists in South Africa];
5. Barriers to entry at different levels;
6. Limited information availability; and
7. Vertical effects.

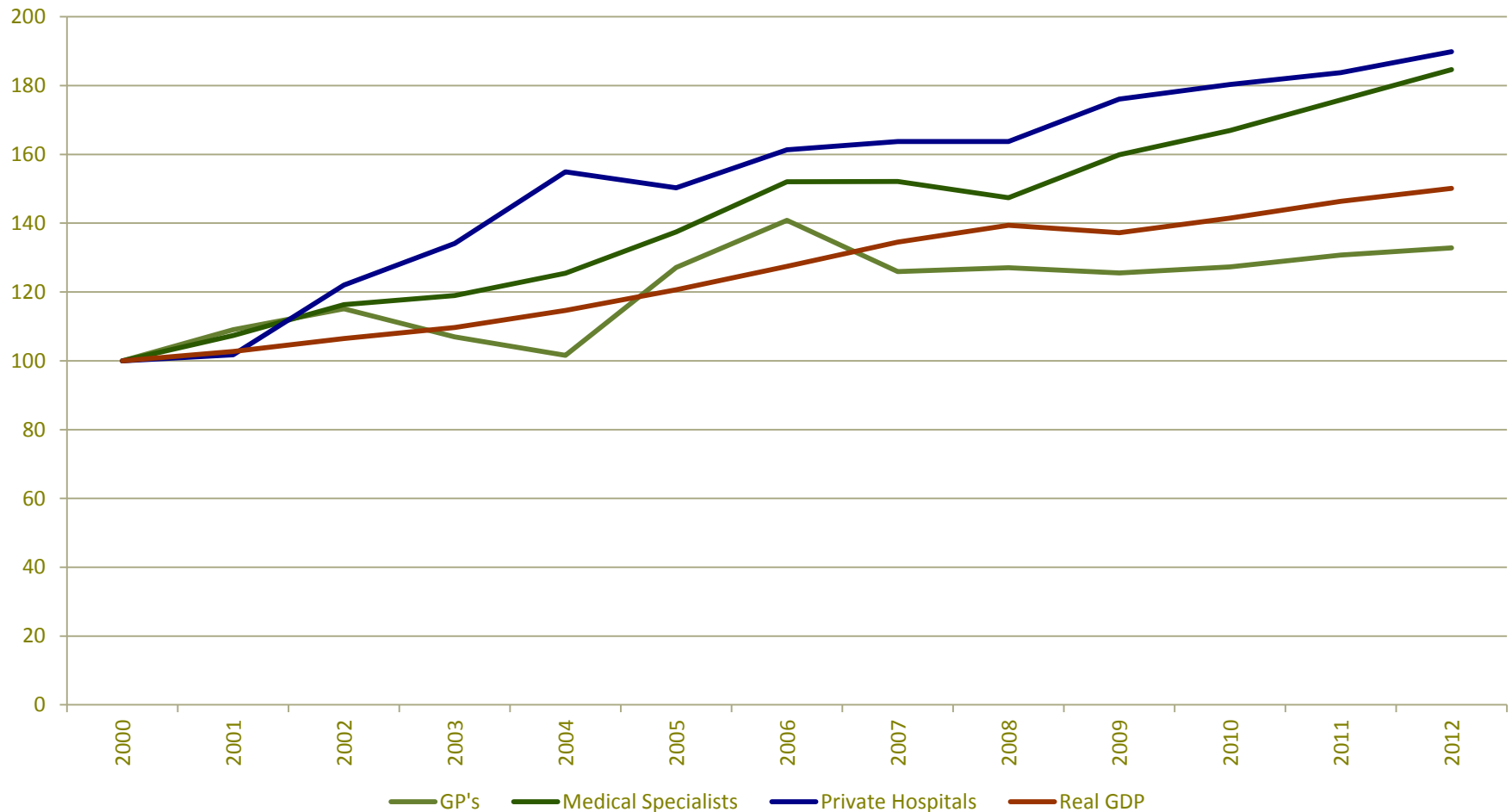
Lessons from international enquiries

- Scope – narrow or wide/ comprehensive?
- Holistic/ integrated approach;
- US (FTC/DoJ) – Increased healthcare expenditures, 14% of GDP;
- Hospitals/ Physicians/ Health Insurance/ Pharma Industry;
- OFT – CMA findings;
- Australia (1997) – Increase in private hospital activity, impact on public patients;
- India – BoD found to be important factor;
- Main lesson: all followed a ‘holistic approach’ – entire sector and all its linkages.

CC's theories of harm

- **Healthcare Financing:**
 - Demand for health insurance;
 - Demand and supply of support services;
 - Purchasing of health goods and services by insurers;
 - Integrity of the regulatory framework.
- **Healthcare Services:**
 - Health professionals;
 - Hospital-based services;
 - Non-hospital based services and healthcare products;
 - Integrity of the regulatory framework.

Theory of harm in healthcare sector (Real spending pabpa – CMS data, index values (2000=100))



| Specific issues - Doctors

- **GPs and specialists:**
 - Issues around pricing (NHRPL);
 - Bargaining power vis-à-vis medical schemes;
 - Specialist fees;
 - Shareholding and other incentives at hospitals;
 - Podiatric clinics/ Protector (2005) – vertical relationship to be investigated;
 - Free rooms, low rent, indemnity insurance;
 - These were found to be problematic by the CMA in the UK (specifically cash incentive schemes and equity).
 - Consultant groups were not further investigated in the UK.

Hospitals

- High degree of concentration;
- Creeping mergers;
- Doctor shareholding and perverse incentives;
- Investment in technology – medical arms race;
- High profits (UK);
- High barriers to entry;
- Regional or local dominance;
- Negotiating power and networks;
- UK – local market power was important (central London)

Hospital Mergers

- Afrox Healthcare Limited and Amalgamated Hospital Limited (53/LM/Sep 01);
- Afrox Healthcare Limited and Wilgers Hospital Limited (15/LM/Feb 02);
- Medi-Clinic Corporation Limited and Curamed Holdings (74/LM/Oc02);
- Business Venture Investments 790 (Pty) Ltd and Afrox Healthcare Limited (105/LM/Dec 04);
- Medi-Clinic Investments (Pty) Ltd and Wits University Donald Gordon Medical Centre (Pty) Ltd (75/LM/Aug 05);
- Phod clinics (Pty) and Protector Group Medical Services (Pty) Ltd (122/LM/Dec05);
- Netcare Hospital Group (Pty) Ltd and Community Hospital Group (Pty) Ltd (68/LM/Aug06 (“Community”));
- Life Healthcare Group (Pty) Ltd Amabubesi Hospitals (Pty) Ltd and Bayview Private Hospitals Ltd (11/LM/Mar10 (“Bayview”));
- Life Healthcare Group (Pty) Ltd and Joint Medical Holdings (JMH) (74/LM/Sep11) (“JMH”)

Competition Tribunal decisions

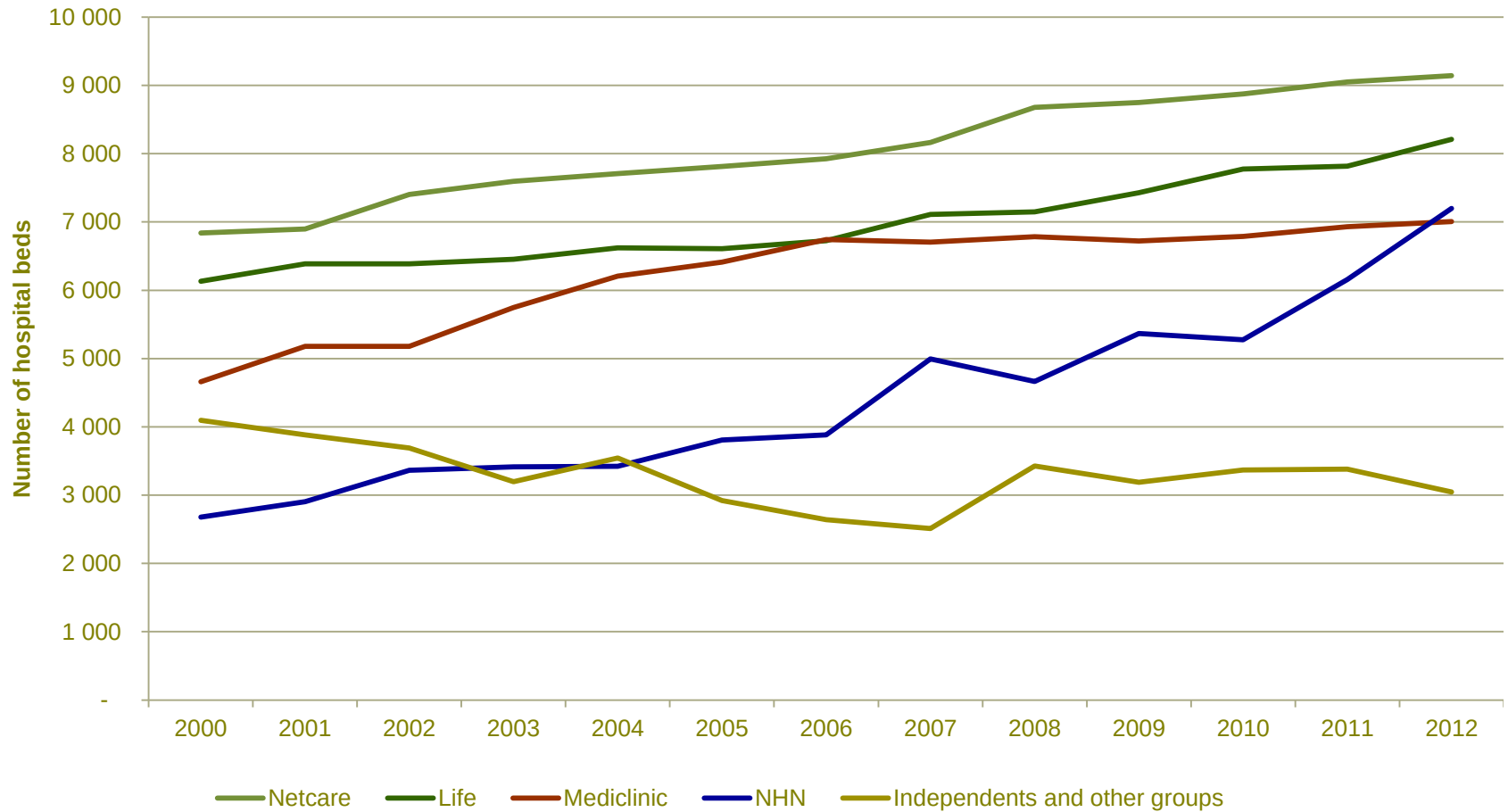
- All approved (some with conditions);
- Key issue: Will hospital concentration lead to higher prices/ tariffs?
- Agreement that prices are determined on a national basis;
- Complex markets;
- Third party payer for insured services;
- Information asymmetry between consumer and provider;
- Consolidations amongst hospitals, but any price effects?

Tribunal decisions

- Significant countervailing buyer power of schemes recognised by Tribunal;
- Although mergers have been opposed by Commission and intervenors, mergers have been cleared by the Tribunal;
- Tribunal looked at non-price local issues;
- But found no exercise of market power/ price increases following consolidations.
- What factors have contributed to cost increases?
- Demand and cost factors.
- MCSA/ Solar Spectrum – Remove exclusivity clause from lease agreement.

Concentration: Evidence from the data:

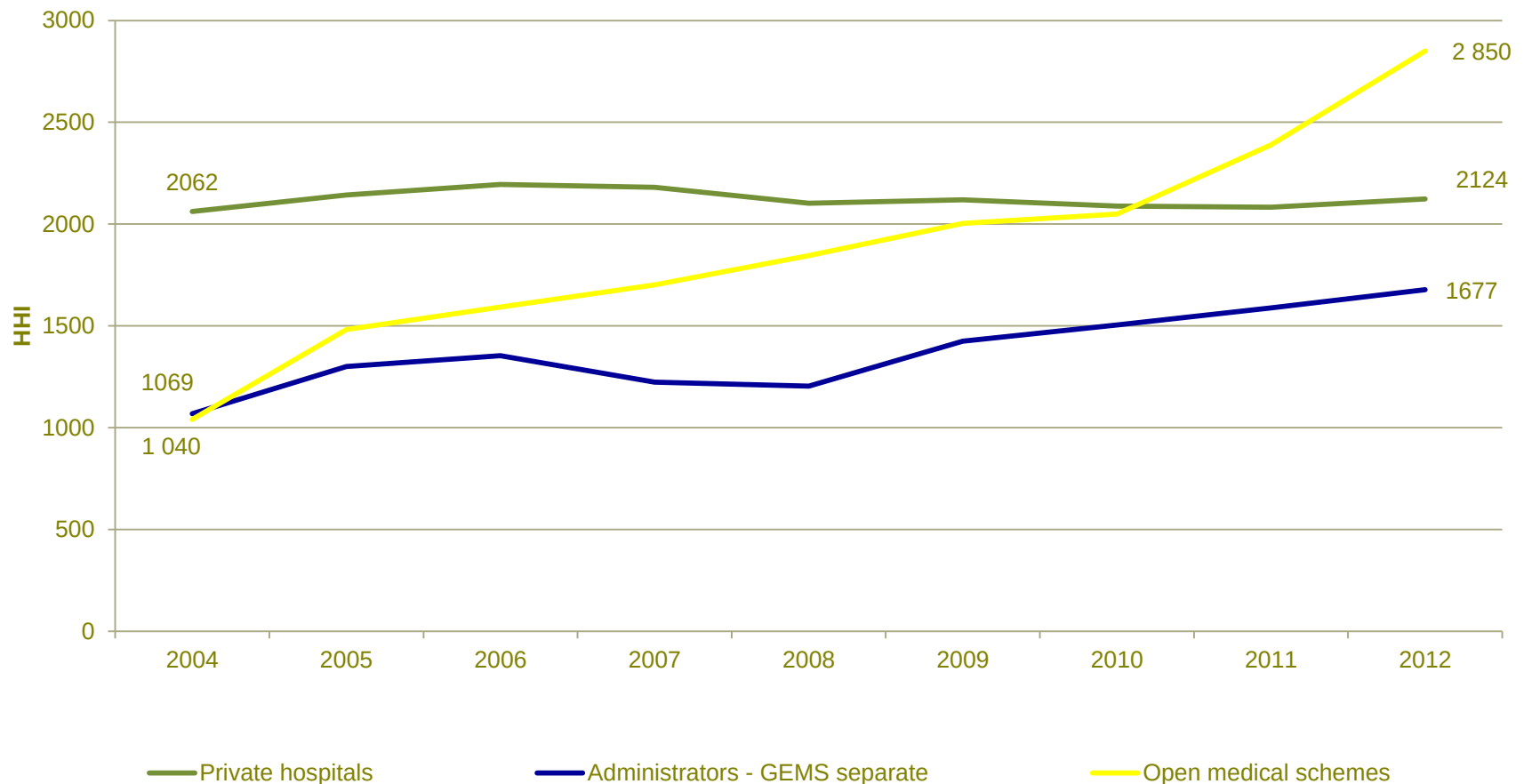
Number of private hospital beds per group, 2000-2012



Market concentration of private hospitals (HHI), 2000-2012



Market concentration (HHI) of private hospitals, medical schemes and administrators (2004-2012)



| Theory of harm from mergers

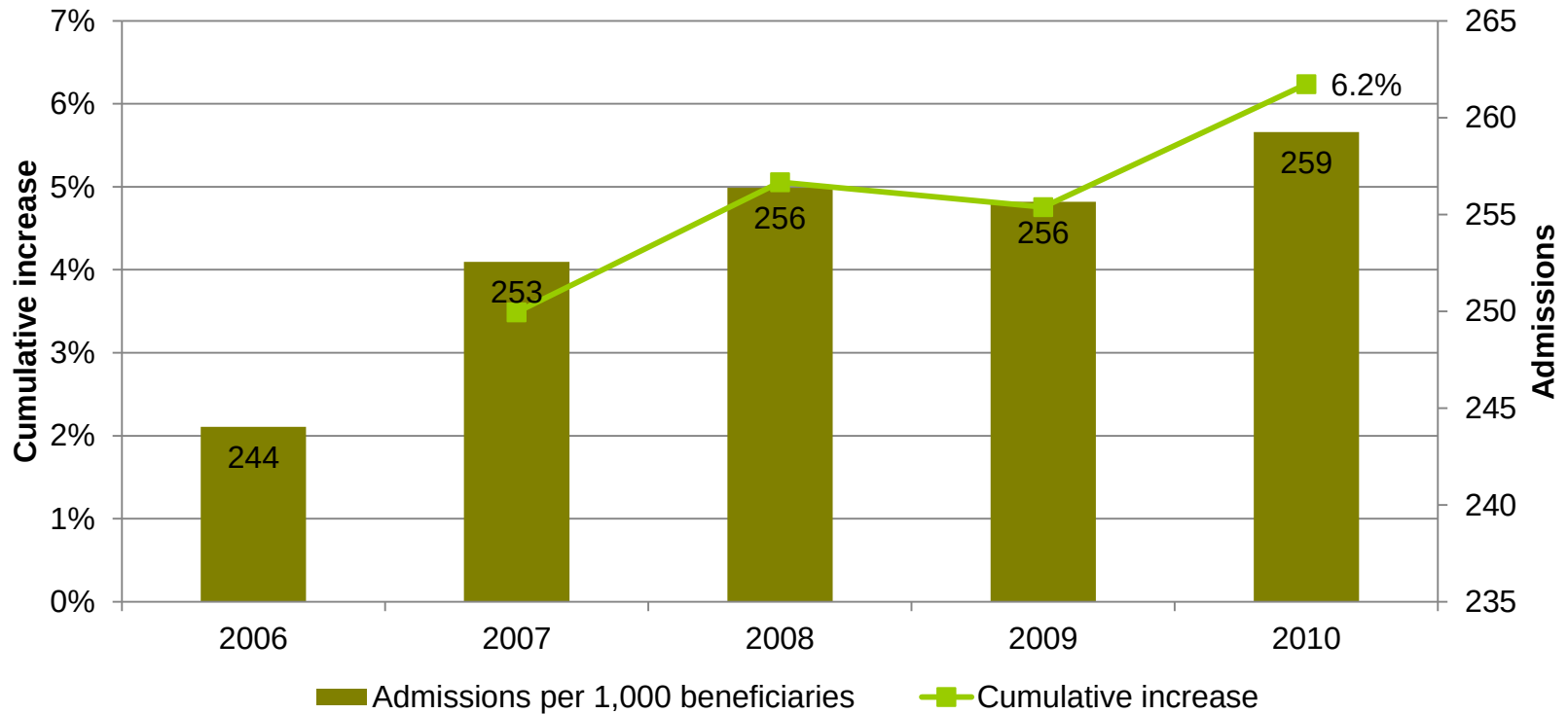
- Key question – determination of prices (does not happen in local markets);
- **Protector:** “We accept that this transaction will lead to an increase in tariffs at the Protector hospitals. For patients who are members of medical schemes this increase is unlikely to affect their contributions since Medi-Clinic’s tariffs have been agreed nationally with their respective medical schemes. Even if the increase in tariffs did result in an increase in the premium for some medical aid patients, this increase would be minimal because Protector has less than 1% of the national private hospital market. For private patients, who constitute only approximately 10% of the patient population at Medivaal, an increase in tariffs of at least NHRPL +19% will take place. However these private patients have between three or five hospitals to choose from in the Vaal Triangle.
- What is the theory of harm?
- Regional schemes/ designated service provider networks;
- Is consolidation/ healthcare mergers driving tariffs/ expenditure?
- What are the real reasons for increasing healthcare costs in the private sector?
- The role of competition policy to address key competition issues in the healthcare sector.

Factors driving costs

- On average 60% of real increase in medical scheme spending on private hospital services are due to factors other than price inflation and beneficiary growth
- Data show significant utilisation increase
 - More admissions (in total and for chronic diseases)
 - Increased length of stay
 - Higher admission rates for elderly members
 - Pharmaceuticals & technology
- Deteriorating disease profile of the insured population
- Institutional factors
- CMS utilisation data inconsistencies
- Hospital price inflation is only a small part of the story

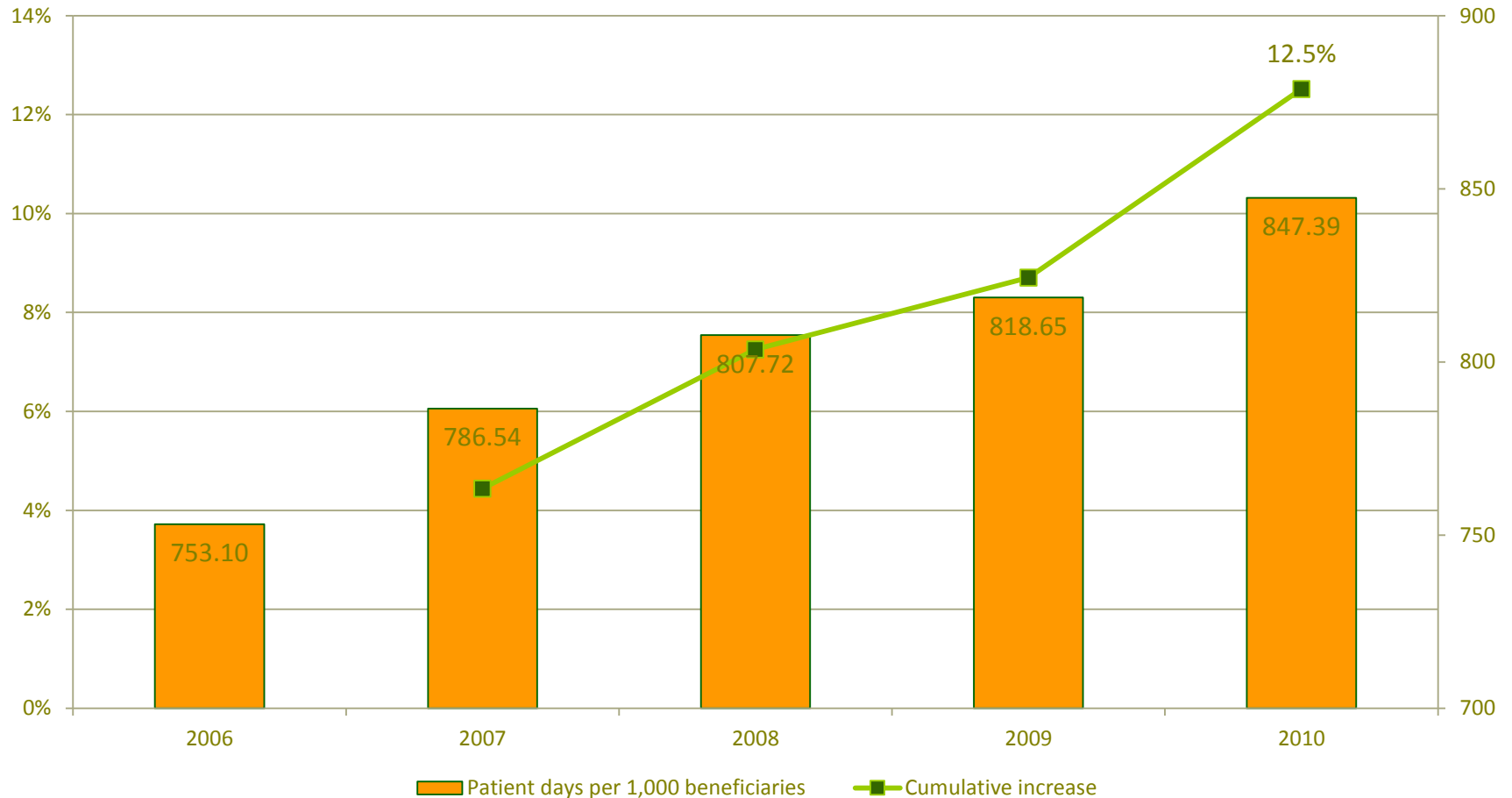
Evidence from the data

Cumulative increase and total inpatient admissions per 1,000 beneficiaries for Mediclinic, Life and Netcare, 2006-2010



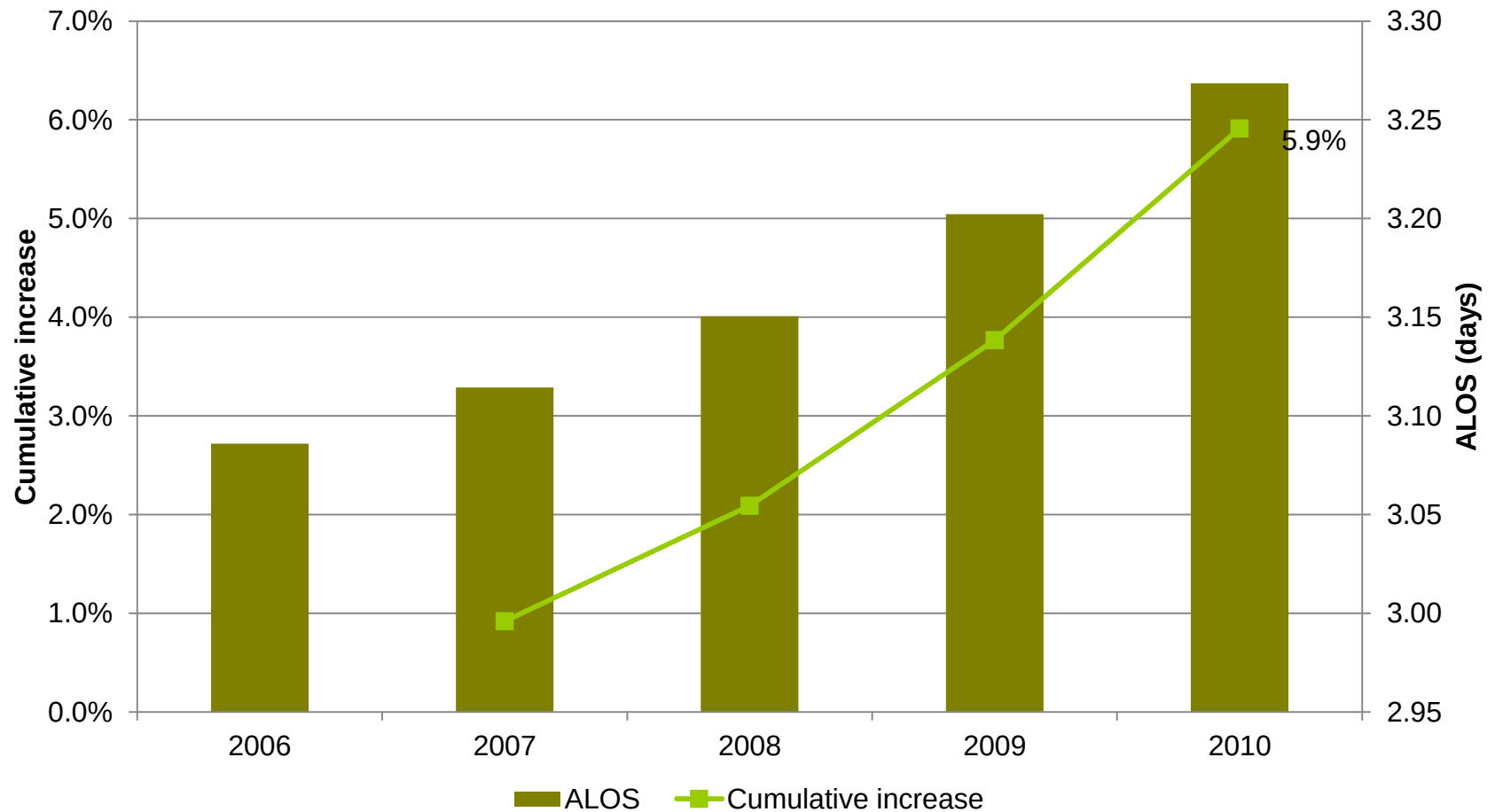
Source: Mediclinic, Life and Netcare data, Econex calculations

Evidence from the data



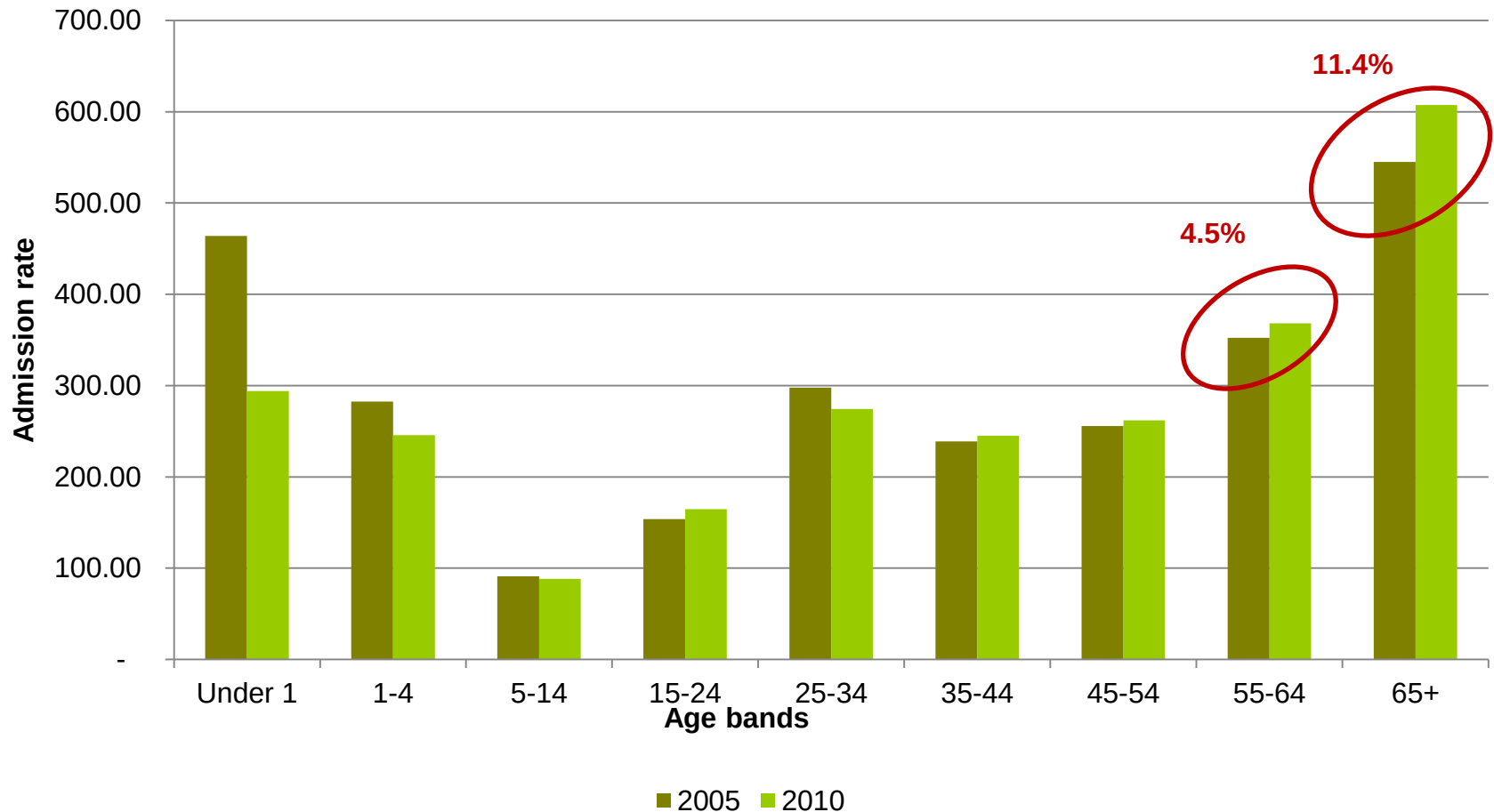
Evidence from the data:

Cumulative increase and ALOS for Mediclinic, Life and Netcare, 2006-2010



Evidence from the data on ageing:

Admissions per 1,000 beneficiaries to the three listed hospital groups per age band, 2005 and 2010



| Funders

- Not the focus of the UK enquiry;
- Administrator fees;
- Buyer power;
- Networks and managed care;
- Local market power of hospitals.

Other issues in CC's ToR

- inter-relationships between public and private systems and implications for competition and cost;
- Inter-relationships between prices (fees and tariffs) and service volumes (volume discounts to funders);
- the extent and impact of markets for substitutes (ie. day hospitals, clinics) on acute in-patient hospital services;
- the relationships between hospitals and nurse practitioners including the role of nursing agencies and the public sector;
- the influence of factors such as population morbidity and demographic profiles on costs and demand volumes;
- alternative reimbursement arrangements and the extent to which they drive competition for hospital services;
- contracts between medical scheme intermediaries and hospital groups outside of any contract with a medical scheme;
- The hospital licensing process and its influence on the market for hospital services;
- the influence of Government's tender processes on product prices;
- the influence of regulatory framework on the effective functioning of the private health market, with specific reference (see terms).
- Doctor's employment– the implications that a market for salaried health professionals (GPs and specialists) will have on provider competition

| Institutional changes

- Medical Schemes Act (131 of 1998) with enabling regulations from 2000
- Increases in cost and volume of private hospital services – increases in monthly contributions
- Open enrolment & community rating, no mandatory membership
- Anti-selection;
- As such, proportionally more people are accessing private hospital services for more severe illnesses
- PMB's

Timelines

Date	Event
31 May 2014	Statement of Issues and Administrative Guidelines issued for public comment
30 June 2014	Receive comments on the Statement of Issues and Administrative Guidelines
1 July 2014 – 31 July 2014	Incorporate comments on State of Issues and Administrative Guidelines
1 August 2014	Publish Final Statement of Issues and Administrative Guidelines
1 August 2014	Call for submissions on subject matter of the Inquiry

Timelines

Date	Event
1 August 2014 – 30 October 2014	Receive submissions on subject matter of the inquiry
1 November 2014 – 31 January 2015	Analysis of information
1 March 2015 – 30 April 2015	Public hearings
1 May 2015 – 31 July 2015	Analysis and targeted public hearings and information requests
October 2015	Publishing provisional findings and recommendations

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