

**REVISED  
STATEMENT OF  
ISSUES**

11 February 2016

Market Inquiry into Private Healthcare

## INTRODUCTION

1. On 1 August 2014 the Health Market Inquiry (HMI)<sup>1</sup> published its initial Statement of Issues (SOI), setting out the theories of harm (TOH) the HMI would be exploring at the outset. Submissions from stakeholders were invited on that basis. This Revised Statement of Issues (RSOI) outlines the HMI's current thinking based on its reading of the submissions received, the evidence gathered and the limited analyses undertaken to date. In this statement we highlight issues which we currently consider as priority focus areas of the HMI going forward. This RSOI should be read in conjunction with the original SOI.
2. The HMI would have preferred to publish the RSOI well before the commencement of public hearings. However, the delay in the provision of data by some of the major stakeholders has hampered the commencement and the finalisation of data analysis. The data requests began in March 2015, with numerous follow-up engagements. Although some important data sets are outstanding, we expect finalisation by the second week of February 2016. The HMI will publish the results of our analysis of data received where relevant and as soon as the data processing and analysis are completed. Accordingly, we must emphasise that this RSOI is based on the incomplete information that the HMI has gathered to date, and consequently also on an analysis that is currently incomplete.
3. The HMI nevertheless considered it necessary to publish this RSOI to inform stakeholders of the progress the HMI has made and to present a more focussed view of the key issues at hand by outlining the tentative thinking of the HMI.
4. The HMI invites stakeholders to comment on the issues set out in this statement. Comments should be submitted by no later than 11 March 2016. Stakeholders who wish to respond to these issues in the course of their oral presentations must indicate their intention to do so prior to the hearings. On 16 February we will commence public hearings and these are expected to be completed on 9 June 2016.

## PROGRESS OF THE INQUIRY

5. The HMI has been in operation from early 2014 and accomplished many of its key milestones in a long and complex process. The RSOI discusses the major elements of the work to date and provides some indication of the issues stakeholders have raised through their various interactions with the HMI.
6. The HMI is presently in the investigative phase which is concerned with gathering evidence on the possible impact of market structure and the conduct of market players on competition in the private healthcare sector.

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<sup>1</sup> Market inquiry into the private healthcare sector in terms of Chapter 4A of the Competition Act 89 of 1998 as amended, with Terms of Reference first published on 29 November 2013 in *Government Gazette* No. 37062 and amended on 16 October 2015 by notice published in *Government Gazette* No. 39299.

7. This investigative phase further involves a refinement of focus areas, the identification, collection and analysis of data and information, the formulation of provisional conclusions on the data and information collected, and the preparation of position papers on specific key topics. This phase will also guide requests for any additional information and clarity that the HMI requires as it enters the public hearings phase.
8. In the administrative phase, which preceded the investigative phase, the HMI received 68 initial submissions from stakeholders totalling in excess of 15,000 pages. Where not restricted by claims of confidentiality in terms of the Competition Act, all the submissions have been published on the HMI website. The majority of submissions concur that private healthcare expenditure in South Africa is high and continues to increase at rates in excess of general inflation. However, the submissions differ significantly on the possible explanations for this phenomenon.
9. Certain submissions attribute the cost increases to market power in three groups of stakeholder: hospital groups; medical schemes and their respective administrators; and specialist medical practitioners. Insofar as market power is concerned, the views tend to vary largely in relation to the stakeholder's location within the market.
10. A number of submissions raise concerns about the regulatory environment. Some have submitted that there is a lack of regulation or adequate enforcement of the applicable regulations due to ineffective oversight by the regulatory bodies. Others have submitted that there is overregulation in certain areas, resulting in barriers to entry, expansion and innovation in the private healthcare sector.
11. Certain submissions argue that regulatory gaps remaining after the introduction of social solidarity principles to the funding side of the system have had adverse consequences on costs, as well as negative effects on the vulnerable people who depend on the private healthcare sector. They argue that the elimination of regulatory gaps will improve market outcomes with positive effects on social solidarity.
12. A number of submissions raise concerns about the lack of information available to patients, highlighting a general lack of transparency in accessing private healthcare information — in particular, on pricing, costs and quality of services. They have submitted that this lack of information places patients at a disadvantage when making decisions on services, and that this disadvantage has implications for competition.
13. A feature of many of the submissions is that, in spite of requests for evidence, data and analyses that inform the opinions contained in stakeholder submissions were largely absent or restricted to very specific (short) periods of time and therefore of limited evidentiary value. The above-mentioned information and data requests to specific stakeholders have aimed, where possible, to fill this gap.
14. Decisions and recommendations on the subject matter of the HMI cannot only be informed by the submissions received, but must also be guided by the Competition Commission's preliminary research, considerations of stakeholder comments on the TOR, the main

- categories of private healthcare expenditure, and the areas the HMI feels are the highest priority.
15. The HMI also seeks to understand the inter-relationships between various markets in the private healthcare sector, including the contractual relationships and interactions between and within the health service providers, the influence they have on the dynamics and functioning of the market, the nature of competition within and between these markets, and the ways in which competition can be promoted.
  16. The HMI also wishes to assess the impact of the Competition Commission's interventions in private healthcare through enforcement action and merger regulation; including any possible impact this has had on prices, bargaining mechanisms, consolidation and competition in the healthcare sector.
  17. All this explains why the HMI has embarked on extensive stakeholder engagements to determine more specifically the framework for the information gathering and analysis phases. This process guided the development of detailed information and data requests which set out the various categories and nature of information that the HMI required to undertake the intended analyses. These engagements will continue throughout the remainder of the HMI.
  18. These engagements with and data requests made to stakeholders commenced in March 2015. The preparation of the data requests was a complex process, as it required the HMI to determine the relevant data sets, the nature and type of information needed, as well as the format for the presentation of data and information required, pursuant to the relevant analyses to be undertaken by the HMI.
  19. Once finalised, the data and information requests were sent to firms in eight stakeholder groups: hospitals; radiology and pathology practices; registered medical schemes; medical scheme administrators; managed care organisations; health insurance product providers; and other relevant parties.
  20. In total, the eight stakeholder groups, representing in excess of 160 individual stakeholders, were requested to provide detailed sets of data and information.
  21. Certain stakeholders, notably hospital groups and certain administrators, required clarity on numerous aspects of the data/information requested distributed to them. This necessitated detailed engagements and regular follow up meetings.
  22. Many stakeholders also requested an extension of time to submit relevant data and/or information. The HMI agreed to grant extensions to 30 June 2015 in some cases. Despite this deadline, however, a number of stakeholders indicated that while a proportion of data would be available by 30 June 2015, certain data sets would only be available by 31 July 2015. Some important data were in fact received only recently, after later requests for information, and, as indicated above.
  23. To properly understand private healthcare in South Africa, as well as the relevant role-players involved, the HMI also conducted more general engagements with a wide range of stakeholders.

24. To date, the HMI has held in excess of 100 separate stakeholder engagements, ranging from general discussions on the roles and responsibilities of certain stakeholders to detailed engagements on submissions, matters of confidentiality, accessing important documents and information, data requests and dealing with various queries.
25. The HMI has also been developing methodology papers for its profitability analysis and for the definition of markets.
  - 25.1. The HMI has published a proposed methodology for assessing profitability. The HMI had the benefit of considering the profitability analyses conducted at the initiative of some stakeholders, including the techniques used, the assumptions made and the results arrived at. The HMI has discussed these analyses with the relevant stakeholders and have requested that they now conduct a profitability analysis using our methodology. The HMI is now in the process of collecting their analyses. Once this process has been finalised the HMI will conduct its own analyses, based on the data provided, and convey the outcome to the relevant stakeholders for comment. This will reflect the techniques used, the assumptions made and the results reached.
  - 25.2. *The HMI is currently finalising a methodology paper dealing with market definition.* As with the profitability analysis, some stakeholders have provided the HMI with their views, in particular how they define the various markets and their assessments of whether or not they have market power. The HMI is in the process of finalising our market definition methodology that will contribute to a determination of whether and where market power exists. This paper will be published shortly and the HMI will at that stage engage further with the relevant stakeholders.

## **MAIN ASPECTS OF THE PRIVATE HEALTHCARE SYSTEM**

26. The task of the HMI, as indicated in the SOI, is to determine whether there are features of the private healthcare sector that undermine competition. The HMI regards "features" to mean any notable characteristics of a market, particularly its structure, its interconnections with other markets, and the conduct of participants within it. The HMI believes that the structure of the private healthcare sector is of central relevance in assessing competition in the sector.
27. With regard to the provision of healthcare services, the private healthcare sector stakeholders can broadly be classified as operating on the financing (demand) and delivery (supply) sides. The financing side comprises consumers, medical schemes, medical scheme administrators, managed care organisations, other health insurers, brokers and public agencies such as the Road Accident and Compensation Funds.
28. On the delivery side, sector participants include healthcare practitioners, healthcare facilities, emergency medical response services, pharmacies as well as manufacturers and suppliers of products like medicines and medical devices. Even though the HMI is primarily about the

private sector, the national and provincial departments of health participation in both the financing and delivery sides are also regarded as important.

29. In addition to core sector participants mentioned above, the South African health market has a wide range of important supporting stakeholders who do not provide services directly to consumers. Instead they supply industry-specific services and products to funders and healthcare providers listed above. Examples of supporting industry players include companies that transmit medical claims between providers and funders, companies that provide practice management services, software vendors, clinical coding companies and medical malpractice insurers.
30. In regard to the private financing of healthcare services, the medical schemes, medical scheme administrators, other insurers and brokers are, of course, on the supply side of the market in relation to the insured patients who, as end consumers or final payers, are on the demand side. The relevant relationships in this regard also form part of the analysis of competition in the private healthcare sector.
31. The rules of engagement within the private system are set and monitored by regulators empowered by various statutes to perform this function. Organisations that play a regulatory role include the national and provincial departments of health, the Medicines Control Council, the Health Professions Council of South Africa, the Allied Health Professions Council of South Africa, the South African Nursing Council, the South African Pharmacy Council, the South African Dental Technicians Council, the Council for Medical Schemes, and the Financial Services Board.
32. The mapping of the private sector players, providing a static picture of the HMI's understanding of the sector will, in due course, be made available in a separate working document to be published on the HMI website. Information supplied by stakeholders, and revealed during public hearings, will be used to further enhance our understanding of the sector and the prevailing market dynamic.
33. To date, there has been limited input to the HMI from the general public, and yet they are the consumers of private healthcare services. It is nevertheless apparent that the information available to various parties in the industry pertaining to the cost and quality of treatment is characterised by imperfect information (poor market transparency). This is a well-recognised problem in healthcare markets internationally, but may have particular national and local features. Imperfect information implies that consumers are disadvantaged when they make decisions on the choice of medical schemes, administrators and healthcare service providers and products. The HMI intends to explore the reasons for this lack of information, its impact on competition and the various options for improving the availability of information to the consumers.
34. The HMI therefore intends to afford consumers an opportunity to express their understanding and experiences of the sector. Generally, the HMI intends to explore the dynamics of the health sector further to understand if there are features, or combinations of features that prevent, distort or restrict the ability of competition to benefit the public.

## THEORIES OF HARM – ISSUES OF INTEREST

### *Approach*

35. The SOI published in August 2014 provided six broad areas where harm to competition in the private market for healthcare is possible. These were referred to as "theories of harm" falling under the following headings:
  - 35.1. Market power and distortions in healthcare financing;
  - 35.2. Market power and distortions in relation to healthcare facilities;
  - 35.3. Market power and distortions in relation to healthcare practitioners;
  - 35.4. Barriers to entry and expansion at the various levels of the healthcare value chain;
  - 35.5. Imperfect Information; and
  - 35.6. Regulatory Framework.
36. This RSOI outlines the issues which the HMI now considers to be the appropriate focus of inquiry. Based on the HMI's understanding of the submissions and the issues they raise, as well as the additional information and data gathered, the HMI intends to explore further the issues set out in this statement below.
37. The work of the HMI is broadly divided into two areas.
  - 37.1. The first is to diagnose the most probable structural features driving any observed adverse market outcomes. Any evidence suggesting anti-competitive behaviour can best be analysed initially in its structural context.
  - 37.2. The second is to evaluate the most effective solutions to possible adverse findings emerging from the diagnostic exercise.
38. The various issues raised in the sections below provide an overview of the direction of the diagnostic exercise, which will now move into a process where it can incorporate the inputs from hearings. The hearings will provide an opportunity for stakeholders to respond to the issues raised in the RSOI and thereby support the work of the HMI.
39. In moving from the original TOH, consideration is given to five factors within the private healthcare system that raise concerns warranting further examination:
  - 39.1. Private health insurance markets are generally understood to face structural vulnerabilities that restrict the completeness of risk-pooling in the absence of regulatory interventions. The adequacy of the regulatory framework towards this end therefore needs to be fully examined.
  - 39.2. Consumers are unable to make informed choices in the selection of health products (i.e. insurance, services and products) due to lack of transparency in the healthcare

sector. The HMI intends to explore the extent to which, if any, information weaknesses reduce the ability of consumers to make informed decisions, and whether this has any implications for competitive behaviour within the sector.

- 39.3. The accumulation of market power and its possible exercise, arising from market concentration of both funders and providers as well as coordinated conduct (vertical and horizontal) if found to exist, may restrict choice and competition so as to preserve a market dynamic that diminishes the role of the consumer in making informed purchasing decisions.
- 39.4. The strong imperative that consumers have to access healthcare services when needed removes or reduces the ability of consumers to defer or withhold demand as costs increase. Although insurance makes access affordable in the short term, poorly incentivised health insurance markets may be accommodating the cost increases of service providers — reducing affordability over the longer-term.
- 39.5. The coherence of the existing configuration of regulatory interventions on the supply-side (services and products) requires careful review to assess the extent to which contradictory objectives are currently pursued with harmful effects for efficient competition.

### ***Risk-pooling failures***

40. ***Health insurers (such as medical schemes) will compete on the health status of applicants or members in the absence of structural regulation that removes this possibility. The resulting market outcome in that event is the systemic exclusion of sicker and older people from coverage, and price competition centring on applicant/beneficiary risk factors rather than on the cost and quality of healthcare services and products.***
41. Risk-pooling failures, which are common to all private healthcare systems, are considered by the HMI to be a central element that may be affecting competition in the South African private healthcare system. This aspect was not specifically addressed in the original TOH.
42. Private health insurance markets emerge to provide coverage for medical needs that cannot easily be funded by households on an out-of-pocket basis, usually referred to as a catastrophic expense. For private insurance to be offered, however, both willing sellers and buyers are required. Despite a valid demand for health insurance, there are constraints to the health insurance products that can be offered. For a seller to offer insurance contracts the contingencies covered must be insurable in a business sense. However, not all health contingencies are insurable.
43. Competing private insurance products are only sustainable if a number of pre-conditions are met: the people insured must be risk averse; the event insured against must not already have occurred (i.e. the risk of the event occurring must be less than 100%, a situation that results in so-called anti-selection - where people apply for insurance only when absolute certainty exists that an expensive health event will occur); the insured must not be able to

influence the occurrence of the insured event; the probability of an event occurring must be independent of that occurring for anyone else insured; and it must be possible for the insurer to quantify the known probabilities for the insured group as a whole.

44. In a private market, therefore, operating simply on ordinary insurance principles, healthcare cover could not be adequately provided for: people with pre-existing conditions (probability of occurrence = 100%); day-to-day care (general visits to a general practitioner) the demand for which is at the discretion of the insured. A free (unregulated) private health insurance market would therefore tend towards providing cover only for a subset of a given population, and only for a subset of possible health conditions – tending toward those with catastrophic cost implications.
45. A free market for health insurance would consequently leave many less healthy people without cover, and, through the pressure of competition, constantly seek ways to exclude covered individuals when they become more expensive to the insurance arrangement. Excluded individuals would therefore become uninsurable even though it would be possible to cover them if insurers were able to collaborate on their inclusion rather than compete for their exclusion. It is for this reason that social insurance schemes are introduced.
46. Social insurance schemes can take many forms. Some of the most important forms, internationally, involve regulated private insurance markets – where the emergence of an uninsurable group is avoided through measures which prohibit insurers from discriminating against poor risks (i.e. sicker people) and which include system-wide pooling schemes to make the cover of poor risks sustainable for the insurers, such as risk-equalisation and/or statutory reinsurance.
47. As risk-equalisation and reinsurance arrangements pool across schemes, incentives to compete by way of risk-rating or risk-selection are largely eliminated. Such social insurance schemes are argued to promote competition on features more important for healthy competition, such as the cost and quality of healthcare delivered.
48. The inability of a free private health insurance market to efficiently provide coverage is therefore potentially resolved through adjustments to the market structure. However, various market failures potentially still remain, applicable to the efficient use of resources, which, if not resolved, will result in adverse market outcomes that could undermine the sustainability of coverage over time which disadvantages consumers.
49. After apartheid, South Africa introduced a partial social insurance framework for medical schemes to address aspects of these failures. This included open-enrolment for open (commercial) medical schemes, mandatory minimum benefits and community rating. Stakeholders have raised concerns regarding the possible implications for competition and market efficiency resulting from a failure to implement all the required structural reforms necessary to address residual risk-pooling failures.

### **Market price and cost distortions resulting from the existence of insurance**

50. ***Pre-payment for healthcare services and products, which in the private sector takes the form of insurance, is generally accepted as an essential enabler of access to health care. However, the existence of insurance reduces and even eliminates consumer responsiveness to price signals. The important role that consumers might play in making healthcare markets work efficiently is thereby substantially diminished, with implications for competition and market outcomes. It is therefore important for the HMI to confirm how the existence of health insurance alters demand and supply choices and thereby market behaviour, and whether opportunities exist to expand the role of consumer choice despite the existence of insurance.***
51. As most private health purchases occur through some form of insurance (often called third party payers), insured consumers face almost zero point-of-service costs. Consumers will consequently be insensitive to the prices and the costs associated with excessive demand. Insured consumers have no incentive to choose healthcare providers more carefully on the basis of cost where funders have not structured this into their plan design.
52. For consumers to make value-for-money choices an environment has to exist that promotes this. The HMI therefore needs to examine the role funders play in promoting scheme members interests - such as ensuring they get the best value for money - and communicating this to scheme members. *Inter alia* this involves looking further into the agency role that funders play on behalf of consumers, and whether and how they design their products and processes to empower appropriate consumer choice.
53. Whereas the HMI sees no alternative to the existence of pre-payment, or insurance, as a means to realise access to private healthcare services and products, it would like to fully understand how to make competition work more normally despite this feature.
54. It would like to explore two options in this regard. First, what are the most efficient means to convey the value of the product (cost and quality) to consumers? Second, what incentive, if any, can be provided to consumers to ensure that they make use of this information to their advantage? In both instances options will need to be contrasted with what occurs at present.

### **Information failures applicable to funders**

55. ***Insurance product complexity reduces the ability of consumers to make informed choices about the value (cost and quality) of coverage purchased. The resulting market outcome is that the suppliers of insurance products have weakened incentives to compete on the value of coverage - with implications for their incentives to actively manage the cost and quality of healthcare services and products.***
56. Consumers are faced with complex medical scheme and health insurance arrangements, the value of which they appear unable to discern unassisted. Not only are consumers apparently unable to determine the value-for-money to them of the coverage (range of health events insured) offered, but they cannot determine the value-for-money of the contracts funders enter into on their behalf with healthcare services providers.

57. Medical schemes, medical scheme administrators and related parties also collect considerable information on healthcare providers and products. This is largely because this information, including relevant diagnoses, is required by law to effect payments. These funders are therefore well-positioned to evaluate the quality of care, and therefore the value-for-money, of all suppliers of healthcare goods and services in the private sector. The HMI will examine the degree to which this information is made available to members to enable them to decide on a provider and the impact, if any, of such disclosure, or non-disclosure, on competition.
58. The HMI wishes to explore the degree to which medical schemes, medical scheme administrators (and related parties) and health insurers compete substantially on the value offered by the healthcare providers contracted to the schemes. We also wish to explore whether the criteria upon which designated-service-providers are selected by medical schemes/administrators are communicated to the consumer. Furthermore we will consider if medical scheme members/ beneficiaries have sufficient information for them to understand the value of the arrangement and easily take steps to avoid out-of-pocket co-payments.
59. At present this appears not to happen, which raises the question as to whether the removal of obstacles to commercially-driven incentives to make this information available, either to members or the general public, will improve competition. The HMI also wants to understand if the failure to provide this information, despite its availability, is an explicit choice of funders, in particular medical scheme administrators and managed care companies, and, if so, why this may be the case.
60. Without appropriate meaningful information consumers are unable to make decisions on their choice of funder based on the cost and quality of healthcare services covered, and are furthermore not sufficiently aided by funders in making informed choices of healthcare products and services. It therefore appears that funders, acting as agents, make choices for consumers on healthcare products and services without informing consumers of the rational basis for these choices.
61. Three concerns consequently arise in relation to the purchase of health insurance coverage (medical schemes and related products): first, the prerequisites for a well-functioning consumer-driven market appear not to be in place; second, the information failures may expose consumers to manipulation by funder-related product suppliers; and third, the incentives of funders to efficiently purchase healthcare services and products is weakened due to disempowered consumers.

***Information failures applicable to healthcare provision***

62. ***The complexity of healthcare services and products substantially weakens the ability of consumers/patients to make choices on the basis of their cost and quality (value-for-money). Providers of healthcare services and products therefore have weak incentives to compete on these factors, with adverse consequences for both cost and quality outcomes.***

63. Although healthcare service providers and funders collect considerable information on diagnoses and treatment, this information is not made available to the public to assist in their choice of healthcare suppliers of services and products. Professional rules enforced by legislation also expressly prohibit doctors from competing directly with each other by drawing attention to service quality and price. Consumers are therefore excluded from making informed decisions, beyond those arising from advice provided by medical practitioners.
64. Structural difficulties also exist with the production of data and information that appear to be outside of the control of private doctors and facilities. Given the complexity of the healthcare system, if data production and reporting are not standardised, its value as information is greatly reduced. It would therefore be important for the HMI to understand the constraints to the production and collection of health data - sufficient for its translation into useful information - for use by consumers and agents (acting in the interests of consumers) within the sector.

#### **Agency failures applicable to funders**

65. ***An agent is one who acts on behalf of another. But this relationship can be abused if the interests of “agent” and “principal” are not fully aligned. The problem can potentially arise in a number of ways. Medical schemes, for instance, act in a sense as agents for their members while supplying them with and charging them for the relevant insurance product, and so too (albeit indirectly) do medical scheme administrators and managed care companies. Information failures related to access to healthcare funding, together with the promotion of medical schemes and other private health insurance, has led to the emergence of other agents in the form of brokers, to provide consumers with advice on the choice of product and product provider. However, the suppliers of health insurance products (whether as medical schemes, related parties to medical schemes, or other health insurers) may coordinate with brokers to influence the advice supplied. Moreover, the level of general information failure may be so severe that brokers themselves face structural barriers to their ability to provide informed advice.***
66. The HMI wishes to assess whether funders have an adequate incentive to act as an agent of consumers in the purchase of healthcare services and products. In this regard, the HMI wishes to understand the basis upon which funders compete, in particular whether they compete through incentive schemes provided to brokers rather than on the value-for-money of their offering.
67. Brokers, acting as agents, advise consumers about the various medical scheme and health insurance products available. However, brokers are paid by the product suppliers (medical schemes and health insurers) in the form of application and on-going fees, creating a conflict of interest with the consumers whom they are required to advise. A central consideration for the HMI is to determine who the broker in reality regards as the principal client: the consumer, the employer, the medical scheme, the medical scheme administrator, the health insurer or financial services conglomerates?

68. In line with the practice of the financial services industry as a whole, consumers are predominantly required by medical schemes and health insurers to make their applications for membership of open commercial medical schemes through brokers. No contribution or premium discounts apply if a consumer attempts to go direct to the product supplier (medical scheme or health insurer). Consumers therefore freely make use of brokers, as their services appear free, but may face a market where it may not be possible to obtain advice from an independent broker.
69. The HMI therefore wants to assess if the absence of any contribution/premium discount for going directly to schemes or insurers results in consumers having little incentive to pay fees directly to brokers wishing to operate independently of product suppliers. The prevailing system of commissions or on-going fees paid to brokers may establish a barrier to entry for brokers wishing to create a market for un-conflicted advice and services. This barrier may be further strengthened by the requirement for contracts between medical schemes and brokers, which allows a scheme to reject member-selected brokers, or any broker that provides independent advice.
70. The HMI also wishes to understand the impact on the private healthcare sector where brokers establish deep commercial relationships with financial services conglomerates (i.e. inter-related firms involving cross-ownerships between holding companies, financial service subsidiaries and medical scheme administrators) who provide advice on, or sell, financial products in addition to medical scheme membership and health insurance. Broker dependence on the relationship to the conglomerate potentially establishes a barrier to entry for truly independent advisors.
71. The HMI wishes to explore whether any failure of funders to contract with providers of healthcare services and products on the basis of value-for-money reflects a degree of comfort that funders have with a market that is not characterised by value-based decision-making or consumer responsiveness to value-for-money. In addition, the HMI will explore whether any such comfort extends to incentives to maintain the market dynamics as they are through the exercise of market power.
72. Employers have in the past played an important role in supporting effective access to medical scheme cover. It is however not clear that the role of the employer is as important in the past as the medical schemes, medical scheme administrators and related parties also collect considerable information on healthcare providers and products. This is largely because this information, including relevant diagnoses, is required by law to effect payments. These funders are therefore well-positioned to evaluate the quality of care, and therefore the value-for-money, of all suppliers of healthcare goods and services in the private sector. The HMI will examine the degree to which this information is made available to members to enable them to decide on a provider and the impact, if any, of such disclosure, or non-disclosure, on competition.
73. It is also of interest for the HMI to understand how the role of employers has evolved and whether they have a future role to play in enhancing competition.

### ***Agency failures applicable to providers***

74. ***Consumers appear to face substantial information barriers when attempting to choose healthcare services and products. As with the market for funders, agents in the form of medical practitioners play an important role in lowering these barriers through their professional advice. However, conflicts of interest, to the extent that they exist, would potentially influence the impartiality and quality of this advice with implications for healthy competition.***
75. Medical practitioners are able to gain financial rewards from their professional advice in at least two ways: first, from the additional services they provide on the basis of their own advice; and second, through vertical relationships of various forms (incentive payments, subsidised rooms, share ownership, holidays or other excursions abroad, etc.) with suppliers of healthcare services and products. In addition, as with funder agents, doctors also face a general information barrier which reduces their ability to adequately advise patients on achieving value-based choices, even were they are incentivised financially to do so.
76. While the agency role of medical practitioners is central to the good functioning of any health service or system, the economic interests of the practitioner may affect the advice and services provided and the nature and outcome of competition.
77. Although patients are poorly positioned to make diagnostic or clinical choices, they are entitled to make choices about which healthcare provider or product to make use of. Which they would be able to do if they were able to timeously access relevant information concerning their value-for-money (cost and quality).
78. What the HMI wishes to explore is whether the clinical choices, which are properly the domain of medical practitioners, can be separated from economic choices, which should be the domain of consumers/patients. The HMI also wishes to explore the consequences that are likely to arise for the sustainability of the private health sector if such a separation is not possible.
79. As noted above, potential concerns therefore appear to the HMI to take two possible forms. First, medical practitioners are able to generate a demand for their own services, and thereby benefit in a commercial sense. Second, medical practitioners can generate additional demand for services and products from parties with whom they have a commercial relationship, and thus also benefit commercially. The implications of the latter concern are of considerably more significance than the former as they would influence the demand and competition for roughly 80% of all health services and products.
80. In both the above instances, medical practitioners have a conflict of interest arising from a blurring of their clinical role and their commercial interests. Incentives to manipulate demand could have two possible effects. First, over-servicing can result, where patients receive unnecessary care – referred to generally as supplier-induced demand. Second, competition can be undermined, with care referrals (demand) determined by the commercial relationships of the medical practitioner rather than the value-for-money offered to

consumers by the healthcare service and/or product provider. Medical practitioners act as gatekeepers to the demand for services and products, providing them with significant economic influence within the market as a whole.

81. Two areas are therefore of interest to the HMI. First, were the market to provide adequate information to consumers, would they be adequately empowered to make choices in their own interests? Second, could these possible conflicts of interest, which may influence the incentives of medical practitioners, be addressed and enable them to operate as informed agents acting in the interests of patients?
82. Although information barriers for consumers could be reduced, it is of interest to the HMI to have clarity on whether the agency role, with respect to economic choices, is an essential pre-requisite for acting on this information. If so, the removal of medical practitioner conflicts of interest increases significantly in importance.

### ***Market power through concentration***

83. ***Market concentration has become a feature of the South African private healthcare system, with substantial consolidation occurring in medical schemes, medical scheme administrators and their related parties, hospital groups and pathology firms. As market consolidation increases, the risk of anti-competitive conduct through the exercise of market power increases.***
84. Various parts of the private health sector have progressively consolidated over the past two decades. This is evident with respect to medical schemes, medical scheme administrators, hospital groups and pathology firms. Two questions arise that are of interest to the HMI. First, what has driven the consolidation? And second, what are the implications of this consolidation for market conduct?
85. Regarding the first question the HMI is interested in whether the consolidation has occurred because of market features specific to the sector, such as the existence of economies of scale or innovation. Alternatively consolidation might have occurred under the impetus of growing market power and with the overriding objective of establishing a greater degree of market power.
86. Regardless of the causes, however, the HMI must consider the consequences of any concentration for the sector as it allows for the emergence of firms that are in a position to engage in what is known as “unilateral abuse of market power”. Market power, where it exists to a significant degree, can potentially be exploited through the unilateral imposition of higher prices and/or manipulation of demand, and maintained or enhanced through conduct with the intention or effect of excluding competitors.
87. It is of particular interest to the HMI to fully understand the consequences of consolidation in two instances, that of medical scheme administrators and that of hospital groups.
88. Hospital groups, over time, have substantially increased their share of medical scheme expenditure relative to all other healthcare services and products. The cause or causes of this relative increase need to be established.

89. It is possible that the explanation, or at least part of it, lies in factors beyond the hospital groups' control. It is also possible, however, that consolidation - and thus increases in firms' market share - has enabled particular hospital groups to exercise unilateral market power to the detriment of consumers, both by increasing prices unnecessarily or by inducing excessive demand. The former might notionally be achieved through price negotiations with (predominantly) administrators who do not effectively assert a countervailing power. The latter is possible through a systematic avoidance of contractual arrangements that would, for instance, transfer the market risk of excessive demand to the hospital groups. It is likewise possible that market power has arisen, and is exercised, through oligopolistic conduct which - without necessarily involving collusion - enables firms to shadow each other's pricing and other supply behaviour without subjecting each other to intense competition. All these possibilities, as well as any others which might be raised in the course of the HMI, have to be carefully examined.
90. Hospital groups also appear able to influence the demand for their services through vertical relationships with medical practitioners, in particular specialists. It is argued that competition between hospitals occurs predominantly through attracting specialists rather than appealing to consumers on the basis of the value-for-money of their services. If so, this approach to capturing demand may contribute to increasing costs and inefficiencies.
91. The HMI would therefore like to assess the extent to which patient demand is allocated through contracts between funders and hospital groups. Or, whether the contracts focus predominantly on prices.
92. It is argued by some stakeholders that the market concentration of medical scheme administrators balances out the possible effects of concentration and any consequential market power of hospital groups. The HMI would like to explore this further and ascertain if this accurately reflects market conditions. An alternative outcome might be that, instead of using negotiations to improve the quality of contracts with health services providers, medical scheme administrators might lack adequate incentives to drive down hospital charges and improve the value-for-money of what they purchase on behalf of consumers. They instead might exercise market power to drive up the prices paid by medical schemes for administration services, thus acting (directly and indirectly) to the detriment of consumers.
93. It is also of interest for the HMI to understand whether medical scheme administrators exercise market power to exclude possible competitors from the market. In particular, the HMI would like to understand the possible role of the relationship between administrators and brokers in this regard.
94. Equally, an exercise of market power by hospital groups may have as its objective, or effect, to control and/or deter possible entry and growth of new and innovative providers - by, for example, the *de facto* closing of the market for newcomers through strategic relationships with specialists. The HMI would therefore like to understand the possible exclusionary effects of various relationships, contractual or otherwise, between incumbent hospital groups and specialists.

### ***Market power through collusion***

95. ***Market power can emerge through collusion, where parties who would otherwise compete, cooperate in their own interests to the detriment of consumers. Of particular interest to the HMI is the conduct of medical practitioners.***
96. Collusion might take the form of formal agreements (e.g. to fix prices) between companies, *de facto* coordinated business practices without a formal agreement, or might result from decisions of business associations. Collusion has the objective, and usually has the effect of, benefitting participants at the cost of consumers.
97. Collusion is distinct from cooperation that is neutral to competition or even pro-competitive. Some forms of cooperation among competitors can serve to enhance efficiency. An example of positive cooperation between hospitals can be on standardising or even pooling information (in certain circumstances). This form of cooperation — provided it is not compromised by anti-competitive aspects — is ultimately in the interests of consumers.
98. The markets for medical practitioner services also involve significant levels of cooperation. Cooperation occurs through independent practitioner associations, which are typically regional in nature, and various national medical associations, with sub-groupings organised by speciality. Decisions by business associations can, however, also have as an objective or effect that competition between providers is unduly restricted. The HMI is interested in determining the role played by medical associations in competition between providers, and what the resulting competitive effects are.
99. Cooperation between providers presently also involves collective negotiations regarding fees and network arrangements with medical scheme administrators and related parties such as managed care companies. It is of interest to the HMI to determine whether, and, if so, to what extent, these collective negotiations involve the exercise of market power to foreclose contracts that could result in more effective competition between practitioners or practitioner groups on the basis of cost and quality of care.
100. The HMI has noted a general absence of diversity in the range of contracts entered into between medical scheme administrators, managed care companies and practitioners. This begs the question as to the degree of vigorous competition. It is not clear to the HMI whether this uniformity arises from the exercise of market power by administrators, or by practitioners through collusive conduct, or whether there is a tacit meeting of minds between administrators, managed care companies and practitioners where all benefit from the resulting status quo — or whether there are other, more innocent explanations.

### ***Fragmented health service delivery***

101. ***Healthcare systems are regarded as fragmented where inefficiencies exist in care pathways. Such problems exist in both public and private systems and can arise because of the organisation of funding, service provision or both. Within private systems standard arrangements that insurers use to reimburse healthcare service providers can reduce the opportunities and incentives to integrate or coordinate***

***patient care. Within the South African private sector the predominant systems of reimbursement appear to reinforce this fragmentation and may thus drive structural inefficiencies.***

102. The private healthcare system in South Africa seems to be fragmented with weak coordination of patients through the complete cycle of care. This could arise from the predominant system of fee-for-service reimbursement and medical scheme benefit design which appears to generate weak incentives to integrate and/or coordinate care. Healthcare providers consequently do not systematically work in teams and do not make use of information or management systems to support patients along the care pathway.
103. Although much information is collected by the private healthcare system, it is not clear if and how it is used to manage care efficiently. The HMI must assess whether the prevalent form of competition incentivises fragmentation rather than the integration and coordination of services, and whether it raises barriers to the emergence of more efficient market participants seeking to offer integrated and coordinated care approaches.
104. It is also possible that the absence of information on outcomes for episodes of care removes any incentive for market participants to continuously improve performance, through greater integration and coordination, relative to competitors. Care may consequently be offered at a higher cost and lower quality than would be the case if care were properly managed and results measured and publicly disclosed.
105. As inefficiencies within competitive markets represent opportunities for new or existing market participants, it is of interest to the HMI to understand why cost-reducing innovation appears so limited. There seem to be two possible explanations for any sustained supply inefficiencies. First, the fragmentation may be an outcome of an over-riding market dynamic which fosters high information barriers, high prices and supply-induced demand. Second, or alternatively, it could arise from a calculated strategy by key market participants able to exercise market power in this regard.

#### ***Barriers to entry, expansion and innovation***

106. ***Barriers to entry, expansion and innovation can arise in three instances: first, from harmful market conduct arising from the exercise of market power; second, from structural market features specific to private health insurance markets; and third, from regulatory barriers. While the exercise of market power is conceptually straightforward, the manner of its exercise in private healthcare markets may be obscure and would need to be carefully determined. Barriers arising from structural features specific to health insurance markets are also subtle and can arise indirectly where innovative new low-cost products cannot enter the market as no incumbent service provider that is able to control the introduction of the new technology has an incentive to incur the financial loss associated with the resulting improved efficiencies (e.g. a new product might reduce patient stays or medical practitioner consultations). Market entry by competitors could address this outcome provided the costs of market entry are not prohibitive. Regulatory barriers also occur where certain***

***minimum standards apply in the case of a licensing or accreditation regime, which may remove incentives to innovate.***

107. The persistence of pervasive market inefficiencies of any kind is suggestive of barriers to competition of one form or another. Some reason must exist why no new market players enter to undercut inefficient incumbents, or why an incumbent sees no advantage in improving its market share through competitive offerings. The HMI therefore seeks to understand the absence of effective market-related responses, including innovative solutions, to what appear to be significant and persistent inefficiencies in the form of high prices, high costs and fragmented service delivery.
108. The HMI would like to understand the nature of any barriers to entry, expansion and innovation and the extent to which they are structural and amenable to remedy. In particular the HMI would like to understand the experiences of market participants who have attempted to introduce competitive products in the face of persistent market inefficiencies, but have been excluded from the market for one reason or another.

### **Government failure**

109. ***Government failure could be argued to exist in any of three forms. First, poorly designed regulation could establish structural market features which weaken competition. Second, regulations which are needed to ensure pro-competitive outcomes may not be adopted. Third, properly designed regulation could be poorly enforced for various reasons (e.g. regulatory capture, or ineffective oversight). Poor regulatory design or implementation can generate unhealthy forms of competition while healthy competition is a possible outcome of good designs and effective implementation.***
110. A plausible argument to explain adverse outcomes in the South African private healthcare system lies with the possible damaging effects of government interventions of one form or another, and likewise of a failure to intervene. Aside from extreme positions that argue that all government interventions in private markets lead to market failures - a view that is not considered persuasive by the HMI - a strong case could be made with regard to specific interventions (or failures to intervene) that appear to harm competition. Such arguments have been made by both private stakeholders and official sources and are listed below.
- 110.1. *Employment by facilities and funders of salaried doctors:* The Health Professional Council of South Africa's ethical rules in terms of the Health Professions Act prohibit the salaried employment of doctors in the private sector on what is argued to be ethical grounds. Domestically this prevents the emergence of facilities that can align the incentives of all staff when, for instance, entering into selective contract agreements with medical schemes. Particularly where this could also contribute to curbing fragmentation in the way services are delivered.
- 110.2. *Prohibition of doctors competing directly on cost and quality:* The Health Professional Council of South Africa's ethical rules in terms of the Health Professions Act prohibit doctors from competing against each other by drawing

attention to their respective costs/prices and the quality of care. It is therefore argued that the Health Professions Act, in allowing and giving force to such a blanket prohibition, impedes the effective functioning of the market.

- 110.3. *Prohibition by the competition authorities of collective bargaining and information sharing:* Collective bargaining between medical schemes and healthcare providers (health facilities and medical practitioners) may be necessary for the rational determination of fee-for-service fees and tariffs. It can be argued that, in the absence of some form of permitted concerted action by way of collective bargaining, and in particular without a general availability of comprehensive and objective cost-related information, it is impossible for the market to resolve the complex requirements of multiple price setting requirements without distortions arising from the exercise of market power by various healthcare service providers.
- 110.4. *The failure of government to regulate provider prices:* The absence of any mechanism to regulate provider price determination in the market exposes funders and patients paying out-of-pocket to excessive price increases. The lack of government to respond can be argued as a form of government failure.
- 110.5. *Prescribed minimum benefit requirements:* Medical schemes and administrators argue strongly that mandating medical schemes to offer certain specified benefits in the current form is a cause of healthcare cost increases. These increases are attributed to: requirements to cover mandatory benefits in full, exposing funders to over-charging in the absence of regulated prices or a regime to deal with over-charging; and the focus on catastrophic coverage, to the exclusion of primary care, which encourages health practitioners to admit patients into hospital for minor conditions. The HMI, using requested data, must assess the degree to which prescribed minimum benefits have been implemented and any consequent effects.
- 110.6. *Medical scheme benefit anomalies arising from the Medical Schemes Act:* The Medical Schemes Act requires that options (health plans) are self-funding within medical schemes, removing the opportunities for more efficiently designed cross-subsidisation (risk-pooling) between options.
- 110.7. *Under-supply of medical practitioners:* Government presently prohibits the private sector from training medical practitioners (doctors and dentists). More specifically it prohibits medical doctors from being taught by universities through private health facilities. It is argued that this results in an under-supply of doctors, which contributes to cost increases as they have sufficient market power to set high fees and favourable contract terms. The HMI must assess whether there is an under-supply of medical practitioners; and if found to be the case, its effect of on the market - in particular in relation to supplier-induced demand. Importantly, the HMI would like to understand whether it is feasible for supplier-induced-demand and an under-supply of practitioners to co-exist in the same market. For instance, it would be important to determine the extent to which certain specialists are substantially

doing the work of general practitioners – which would be consistent with an over-supplied market.

- 110.8. *The licensing of health facilities creates barriers to entry:* The licensing of health facilities includes both hospitals and specialised equipment and is implemented by provincial health departments. It is argued that the licensing process limits the natural market entry of new facilities and equipment, with the result that markets become concentrated – thereby compromising competition. The HMI must assess the degree to which provinces have or have not been restrictive in allocating licenses. The HMI must also assess if the licensing framework has been used to achieve more market diversity and to regulate improper conduct by hospitals and practitioners.
- 110.9. *Prohibition of competing for-profit health insurance products:* The Medical Schemes Act prohibits market entry for any health insurance product that "does the business of a medical scheme", unless it is registered as a medical scheme. This restricts the entry of competition on the funder side of the market, unless they are structured and regulated as a medical scheme. The HMI must evaluate whether an open market for health insurance which is permitted to discriminate against poor health risks would structurally harm the achievement of healthy and fair market outcomes and its effect on access.
- 110.10. *Failure of Government to implement social health insurance arrangements:* The failure to implement the social insurance environment, raised by many stakeholders, may arise from government failures, but could equally be a failure to respond to market failure. The HMI must assess whether the need for structural regulation as well as the consequences of both partial and complete implementation.

### **External factors**

111. ***Factors that could explain the observed adverse market outcomes can be seen as arising from factors beyond the control of market actors. These are referred to here as external factors.***
112. Various factors are argued to contribute to "perceived" adverse market outcomes within the private healthcare system. Although discussed in various ways by stakeholders, the HMI categorises these factors as possibly external to the influence of the commercial actors within the system. The HMI is consequently reviewing these factors and their possible contribution to the adverse outcomes observed within the industry.
113. These include:
- 113.1. *Ageing of the covered population:* As people age their health status deteriorates predictably (on average), with a consequent increase in the need for more health care. In particular chronic diseases, cancers and cardiovascular conditions are more prevalent in older age cohorts. The average treatment costs for a group of 70-year olds is therefore far higher than for a group of 20-year olds. As populations age,

therefore, the average cost of healthcare can be expected to rise as a generally sicker population needs to be cared for. It is argued that this explains the increased admission rates by medical scheme patients seen in South African private hospitals.

- 113.2. *Technology change*: New technology is expensive and constantly introduced within the South African market. In a competitive market innovation may be expected to reduce costs and replace expensive technology. However, it is argued, by medical schemes, that it is difficult to avoid accommodating costly new technology. The question arises whether the introduction of new technology is always proven to be beneficial to health outcomes and who the accommodation of new technology benefits? It will be important to determine why the entry of new technology always generates systematic cost increases and why competition fails to generate a different result.
- 113.3. *Nurse salaries*: Within the South African private healthcare system nurses are predominantly a feature of facility-based services. The dramatic increase in hospital-based claims, when measured on a per capita basis, is argued to be, in significant part, driven by nurse salary increases. Public sector salary increases are argued to play an important part in private sector increases as the private facilities compete for staff with public facilities. The HMI must assess if the nurse salary increases are correlated to the per capita claims increases of private hospitals and the degree to which they have contributed to the increases experienced by the sector from 2000.
- 113.4. *Baumol's disease*: The health sector is labour intensive, with the unavoidable need for patients to be seen by health professionals with little change over time in the patient contact requirements. Baumol's disease, first espoused in relation to the performing arts industry, argues that certain industries are not prone to labour-saving productivity increases, leaving them vulnerable to annual real increases in labour costs through superficially benchmarking against industries where remuneration increases are derived from genuine productivity improvements. If this is the case it is important to determine the extent to which any such effect contributes to the billing increases charged to medical schemes. Similarly the HMI must assess the proportion that can be ascribed to medical practitioners' increases and understand the reason why providers are able to demand and receive sustained structural remuneration increases with no demonstrable productivity improvements.